Maternal and Child Health Services
Title V Block Grant

State Narrative for Montana

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Montana Department of Public Health and Human Services complies with all required assurances and certifications for federal grants. Copies of the required documents may be accessed through the Director's Office at http://www.dphhs.mt.gov/directorsoffice/.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Family and Community Health Bureau (FCHB) is the designated Title V Agency for Montana. The Bureau's goal for the 2010 needs assessment and the 2011 MCH Block Grant Application and 2009 Annual Report was to ensure active, public input and partner involvement in the planning of those documents and reports.

The Family Health Advisory Council was not reappointed by the Governor in 2009, due in part to an effort to decrease the number of advisory groups. Instead, the Public Health System Improvement (PHSI) Task Force, a group already charged with overseeing and providing input to Montana's Preventive Health and Health Services Block Grant was selected to provide public input. The PHSI was established in 1993 with the purpose of advocating for statewide public health improvement efforts. Its membership includes representatives from local health departments (one each from large, medium, small, and frontier-sized counties) and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service. Additional information about the PHSI Task Force is included as an attachment.

In order for the MCH Needs Assessment process to be effective, the needs assessment participants were briefed on the yearly MCH Block Grant Application and Annual Report contents. As mentioned elsewhere in this document, i.e. II. Needs Assessment, C. Needs Assessment Summary and in more detail in the 2010 Montana Maternal and Child Health Needs Assessment document, there were numerous venues for public input. Over the course of developing the 2010 Montana Maternal and Child Health Needs Assessment, 226 health care professionals; 115 MCH partner organizations; 40 key informant interviewees; and 49 parents who had children with special health care needs, 53 adolescents, and 49 parents of children aged 0 to 12 years through their participation in Focus Group discussions held in four communities and one American Indian Reservation. All of these individuals were enlightened on the MCH Block Grant Application and Annual Report.

The 2010 MCH Needs Assessment and the 2011 MCH Block Grant Application and 2009 Annual Report will be posted on the FCHB's webpage after July 15, 2010. At that time, the PHSI Task Force members and the interested parties will be sent information electronically about the documents' posting and they will be invited to offer their comments on these documents. To simplify this process, the FCHB has created a separate email account HHS MCH BlockGrant@mt.gov, for comments that will be shared with the FCHB and the PHSI Task Force. These comments will also be used, when applicable, on future MCH Block Grant applications.

The FCHB will continue to solicit input on the yearly application through the Pre-Contract Survey, which is contractually required of the health departments accepting MCH Block Grant funding. Additionally, the PHSI Task Force which meets regularly will be kept apprised of the MCH Block Grant Application and Annual Report.

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Family and Community Health Bureau (FCHB) regards the needs assessment process as an ongoing, bureau-wide activity due to the interest and involvement of state and local partners -- particularly those who contract for MCHBG finding -- in improving MCH in Montana. To continue to build on the 2005 Needs Assessment, an existing Bureau team with membership from all programs in the Bureau was expanded and became the Needs Assessment Team that developed a process for the 2010 needs assessment.

A statewide preliminary planning survey was conducted in the summer of 2008 with MCH partners to solicit feedback regarding previous methodologies, data gaps, and representation. This survey resulted in an initial list of priority needs and recommendations for conducting the needs assessment and an overall suggestion for enhanced public input, greater partner involvement at the state and county level, and a systematic approach to identifying problems and possible solutions.

Montana's needs assessment process included focus groups with priority populations, surveys of public health professionals, and interviews with key informants who had MCH experience. The focus group populations were determined based on a review of data sources. Priority populations were selected, in part, to augment assessment for populations with limited data, including adolescents and parents of Children and Youth with Special Health Care Needs (CYSHCN). A survey of public health professionals, which was conducted in the summer of 2009, identified local organizations serving the MCH population in Montana. Key informant interviews provided in depth data from partners who worked in either a public or private MCH related organization.

The qualitative and quantitative data collected by the FCHB, was presented to the Public Health System Improvement (PHSI) Task Force in Winter/Spring 2010. The PHSI Task Force membership includes representatives of local health departments (one each from large, medium, small, and frontier-sized counties), and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service. The Task Force was charged by the Division administrator with the responsibility to assist staff to finalize Montana's 2010-2015 list of MCH priority areas and performance measures.

During the previous needs assessment process, priority areas were developed independent of the performance measures. While all but one of the previous priority areas related to at least one state and national performance measure, they were more directly correlated with objectives in the Bureau's strategic plan. For the 2010 needs assessment process, priority areas were identified simultaneously with performance measures, and the relationship of those priorities to the Bureau and Division strategic plans was also considered. Only areas with an identified measure that were relevant at the state and/or local level were chosen. The 2010 -- 2015 MCH priority areas include: child safety/unintentional injury; access to care, with a focus on children with a special health care need, i.e. cleft lip and/or palate; preconception health; smoking during pregnancy; oral health; Montana's Varicella immunization requirement; and Montana's Diptheria, Tetanus, and Pertussiss immunization requirement.

The next step is the creation of action plans for the priority areas and related state performance measures through a cooperative activity between the state and local contractors. The MCH

contracting process requires that local contractors complete a "pre-contract survey" in the spring of each year, indicating the state or federal performance measure that local efforts will focus on during the contract period. Local contractors are also required to describe evidenced based activities they will employ to address the selected measure. In FFY 2010, local contractors are being asked to provide their selected activities as short, open ended answers on the surveys -- state staff will compile and categorize those responses by level of the pyramid in anticipation of the FFY 2011 pre-contract survey. State staff will research all proposed activities to find sound scientific evidence to support action plans being prepared at the state level. This participatory process allows locals to contribute to the development of action plans for performance measures.

An attachment is included in this section.

III. State Overview

A. Overview

PROCESS TO ESTABLISH TITLE V NEEDS AND PRIORITIES:

Montana's Title V Program provides leadership and direction for state and local programs and partners to identify issues affecting the health of Montana's MCH population. The Title V Program functions within the Family and Community Health Bureau (FCHB) in the Public Health and Safety Division (PHSD) of Department of Public Health and Human Services (DPHHS). The Title V activities support Montana's MCH population issues and needs. Bureau activities include reviewing epidemiological data and information from stakeholder and public input activities, ensuring state and local staff are adequately trained in MCH program and policy development, development and implementation of evidence based programs and services addressing the health needs and risks impacting the MCH population, partnering to develop client services data systems and quality assurance for service delivery, and communicating regularly to manage the Title V Program at both the operational and population health levels.

During FY2009, in preparation for the Maternal and Child Health Block Grant (MCH BG) application, Montana conducted an assessment of the health needs of women, infants, children, adolescents, and children with special health care needs in the state. The assessment consisted of various components including a review of subjective and objective data with state and local parties to ensure coordination of services. The assessment consisted of consumer input through focus groups, key stakeholder interviews, and professional judgment from those working in the field. The needs assessment process and resulting priority areas are more fully described in other sections and in the 2010 MCH Needs Assessment document, which is included with the 2011 application. The 2010 MCH Needs Assessment is a valuable tool for guiding the state's current and future MCH Block Grant applications.

Montana utilizes the Public Health System Improvement Taskforce (PHSI TF) as the advisory group which assists state staff to examine data and develop plans. The PHSI TF was created in 1993 and is responsible for implementing a statewide strategic plan for public health, developing policy recommendations and advocating for public health (PHSI TF Charter). The PHSI TF also serves as advisory for the preventive health block grant.

The FCHB's role in addressing these priority areas is through the major functions of public health, which are assessment, policy development and assurance. The Bureau may serve primarily to inform partners about the issue (assessment), may establish programs and services to address particular issues (policy development), and/or may work with public and private partners to facilitate access for the MCH population to needed services (assurance).

INTRODUCTION: Montana's geography, nature of her minority groups, political jurisdictions, economic characteristics, population size and distribution have a profound effect on the health of her citizens, how direct and public health services are provided, and on the enormity of health disparities in the state. These factors affect both the State's health priorities and initiatives and the process for determining those priorities.

GEOGRAPHY: Montana is the fourth largest state in the United States, encompassing 145,552 square miles, 56 counties, and 7 Native American reservations. Western Montana is mountainous, heavily forested, dotted with waterways, and has several state parks and state forest areas. The eastern two-thirds of the state are semi-arid to arid and access to water is often a concern. Annual precipitation averages less than 15 inches.

ENVIRONMENTAL CONCERNS: Montana's environmental history includes extraction of natural resources. Currently, the majority of the land is used for agriculture and the production of oil, gas,

lumber, and coal. Limited mining for copper, silver, palladium/platinum, and gold continues. However, these extraction processes have left a legacy of environmental pollution. In 2010, Montana had 15 Federal Super Fund sites and 209 Comprehensive Environmental Cleanup Responsibility Act (CECRA) priority facilities . The vermiculite mines in Libby, Montana were shut down in 1990. A medical screening program conducted by the Agency for Toxic Substances and Diseases Registry (ATSDR) and the State of Montana Department of Public Health and Human Services (DPHHS) has disclosed that several hundred people were exposed to asbestos contaminating the vermiculite and have evidence of asbestos-related diseases. According to the Environmental Protection Agency (EPA) in 2010, small sources of vermiculite are still found in a variety of places in and around people's homes and businesses. However, air monitoring indicates it is safe to walk the streets of Libby. Forest and range fires routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

POPULATION CHARACTERISTICS: The U.S. Census reports the 2009 population estimate to be 974,989, 44th in terms of population, with a population density of 6.6 people per square mile. The 2009 population estimates for Montana suggest an overall increase of 8.1% from 2000. The instate population has been redistributing to the western portion of the state and into urban areas over the last decade. The 2008 estimate projects that Montana has six counties with a population over 50,000 people and that 59% of Montanans reside in these six counties. The remainder of the population is dispersed into smaller communities, farms, and ranches . In 2000, Montana had 0.3% of the total population of the United States, with little change projected by the census for 2009. It is projected that Montana will have an 11% increase in population from 2001 through 2015, 28th in population growth for the time interval. Anticipated population for 2030 is 1,044,898, ranking 27th in the nation for population growth .

AMERICAN INDIAN POPULATION: According to the 2008 Census estimate, there were 62,399 self-identified American Indians in Montana, or about 6.4 percent of the total population. Approximately 37,871 American Indians, or about 57.4 percent, lived on one of the state's seven reservations. The Blackfeet and the Flathead reservations were the largest, with 8,665 and 7,853 American Indian residents, respectively. Rocky Boy's (2,598) and the Fort Belknap (2,805) reservations were the smallest.

AGE: The median age in Montana for 2006-2008 was 39.3 years, higher than the national average of 36.7 years. 6.3% of the Montana population was under 5 years of age and 23% was under 18 years of age, compared to 6.9% and 24.5 % of the US population. Montana's population is split evenly between males and females. According to 2009 U.S. Census Bureau Estimates, women of reproductive age (15-44 years) comprise 17% of the state population .

ACADEMICS: Montana's graduation rate for public high school students for the 2005-2006 school year was 82% compared to the national average of 73%.

Mathematics, Grade 8--the percentage of students in Montana who performed at or above the National Assessment of Educational Progress (NAEP) Proficient level was 44 percent in 2009. This percentage was greater than that in 2007 (38 percent) and was greater than that in 1990 (27 percent). The percentage of students in Montana who performed at or above the NAEP Basic level was 82 percent in 2009. This percentage was greater than that in 2007 (79 percent) and was greater than that in 1990 (74 percent). In 2009, students who were eligible for free/reduced-price school lunch, an indicator of poverty, had an average score that was 22 points lower than that of students who were not eligible for free/reduced-price school lunch. This performance gap was not significantly different from that in 1996 (24 points). In 2009, the average mathematics score in Montana was

- lower than those in 2 states/jurisdictions
- higher than those in 44 states/jurisdictions
- not significantly different from those in 5 states/jurisdictions

Reading, Grade 8-- The percentage of students in Montana who performed at or above the NAEP

Proficient level was 38 percent in 2009. This percentage was not significantly different from that in 2007 (39 percent) and was not significantly different from that in 1998 (40 percent). The percentage of students in Montana who performed at or above the NAEP Basic level was 84 percent in 2009. This percentage was not significantly different from that in 2007 (85 percent) and was not significantly different from that in 1998 (83 percent). In 2009, students who were eligible for free/reduced-price school lunch, an indicator of low income, had an average score that was 14 points lower than that of students who were not eligible for free/reduced-price school lunch. This performance gap was not significantly different from that in 1998 (17 points). In 2009, the average score in Montana was

- lower than those in 2 states/jurisdictions
- higher than those in 39 states/jurisdictions
- not significantly different from those in 10 states/jurisdictions

ETHNICITIES: Montana is predominately white with an estimated 90.5% of the 2008 population reporting Caucasian as the primary race, compared to 79.8% in the nation. Eleven American Indian tribes make up the largest minority population in Montana, representing approximately 6.4% of the total population (62,399), the 5th highest state in the nation.

Census Population	2000	2009 Estimate
White	90.6%	90.5%
Black	0.1%	0.7%
American Indian	6.2%	6.4%
Asian	0.5%	0.6%
Native Hawaiian/ Other Pacific Islander	0.1%	
Two or more races		1.7%
Other	0.6%	

BIRTH & FERTILITY RATES: The Montana birth rate declined from the early 1980s to 1999. The rate of births to Montana residents leveled off and has increased in recent years. It grew to 13.2 per 1,000 residents in 2006 and fell just a bit in 2007 and 2008 to 13.0 . As with many small population states, Montana's health indicators may change dramatically from year to year, leading the public and sometimes policy makers to assume associations between programs and activities and outcomes. In fact, what may appear to be dramatic changes, such as a child death rate dropping to 25 per 100,000 children aged 1-14 in 2005, down from a rate of 33 in 2000, may be due to very small changes in actual numbers.

In 2008, the fertility rate for Montana's white mothers of all ages was 66.2, the birth rate for white mothers between the ages of 15 and 17 was 14.5, and the rate for white mothers between the ages of 18 and 19 was 62.4. Fertility rates for Native Americans were substantially higher in these age groups--107.8, 55.1, and 188.3, respectively. American Indians account for about 6.4% of the total Montana population, and more than 12% of births.

Minority groups that may not be captured by census data, but that may have unique health issues, include migrant and seasonal farm workers and religious groups such as the Hutterites.

INDIAN HEALTH SERVICES, TRIBAL HEALTH ENTITIES & POLITICAL JURISDICTIONS: According to the U.S. Census Bureau designations, the state has 3 metropolitan areas (an urban population core of 50,000 or more) and 5 micropolitan areas (an urban population core of 10,000-49,999). However, the majority of the 56 counties are still considered rural or frontier. Fifty-four county health departments contracted with the DPHHS in FY 2010 to provide Maternal and Child Health (MCH) and other health services. The local health departments are county entities under the control of local Boards of Health and the staff are county employees. The seven Indian reservations are sovereign nations and home to 11 American Indian tribes occupying 8.4 million acres. This status, coupled with the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for common

clients between the two service delivery systems.

INDIAN RESERVATIONS and COORDINATION OF SERVICES: The local city/county health departments are contractually required to establish a memorandum of understanding regarding coordination of services with Indian Health or Tribal Health Services, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. Several MCH programs, i.e. Public Health Home Visiting, Cleft Palate Outreach Clinics, are operating on several reservations with a continuing goal to increase the number of partnering reservations.

ECONOMIC ENVIRONMENT

MONTANA WAGES: Among the states with annual pay below the U.S. average, Montana posted the second lowest average pay ($33,305) in 2008. The lowest pay level was in South Dakota ($32,822). The next lowest pay levels were Mississippi ($33,508), Idaho ($33,897) and Arkansas ($34,919). The 2008 average annual pay figures for these states, which account for only 2.8 percent of the nation's workers, were 25 to 28 percent below the national average. Average annual pay levels for 36 states were below the U.S. average in 2008; combined, workers in these states accounted for 52 percent of the nation's covered employment .

FEDERAL AID: Montana taxpayers receive more federal funding per dollar of federal taxes paid compared to the average state. Per dollar of federal tax collected in 2005, Montana citizens received approximately $1.47 in the way of federal spending. This ranks the state 11th highest nationally and represents a rise from 1995 when Montana received $1.46 per dollar of taxes in federal spending (6th highest nationally). Resources supporting state level efforts for the MCH population, including Children & Youth with Special Healthcare Needs (CYSHCN), are overwhelmingly federal. Less than 5% of funding for the Public Health and Safety Division (PHSD), which houses the FCHB, is from the state general fund.

POVERTY: According to the U.S. Census Bureau's Current Population Survey, Montana's estimated poverty rate was 14.1% in 2007, which was above the national estimated poverty rate of 13.3%. Montana had the 16th highest poverty rate in the U.S. in 2007. From 2002 to 2007, Montana's poverty rate varied from a low of 13.6% in 2004 to a high of 14.6% in 2005. The percentage of near poor, those with incomes below 125%, 150% and 200% of the Federal poverty level, was higher in Montana than nationally. Montana counties reporting the highest poverty rates in 2007 include Roosevelt (30.3%), Glacier (26.6%) and Big Horn (26.4%). These three counties had poverty rates that were over 26%, with Roosevelt's rate (30.3%) being over twice as high as the state average (14.1%). Of the 56 counties in Montana, 36 of them held poverty rates above the national average of 13% in 2007. The lowest poverty rates were reported by Fallon (9.3%), Sweet Grass (9.4%) and Yellowstone (9.7%) Counties in 2007.

In 2007, about 15.7% of children under 18 years of age lived below the poverty line in Montana, while about 18% of the same age group lived below the poverty line in the U.S. About 13.2% of Montanans age 18 to 64 lived below the poverty line in 2007, while about 10.9% of this age group lived below the poverty line in the U.S. While 6.7% of individuals age 65 and over lived below the poverty line in Montana, about 9.7% of individuals age 65 and over lived below the poverty line in the U.S. in 2007.

AMERICAN INDIAN ECONOMIC CHARACTERISTICS: Health care and social assistance are the primary employers of American Indians in Montana. These two industries employ about 3,353 American Indians statewide. Public administration (which includes all forms of government) and educational services were second and third, employing 3,200 and 2,660 respectively. The median household income for American Indians was $22,824, far less than the $33,024 reported for all Montanan households. The median household income on the Crow Reservation was $28,199, compared to the $18,484 reported on the Fort Peck Reservation. A closer look at the figures reveals that the Crow Reservation reported by far the lowest percentage in the less than $10,000 income category. Furthermore, there were relatively more households on the Crow

Reservation in the middle-income categories from $30,000 to $99,000. These households may include people with relatively good-paying mining and Bureau of Indian Affairs (BIA) hospital jobs.

UNEMPLOYMENT: In 2009, Montana's unemployment rate has been lower than the U.S. According to the U.S. Department of Labor, Montana's unemployment rate in 2009 was 6.2%, compared to the U.S. rate of 9.3% . Unemployment on the reservations ranged from 8.5% to 16.3%, according to the 2009 Montana Reservation Labor Force Statistics. Data on poverty in Montana continues to demonstrate disparities between the population as a whole compared with the seven Indian Reservations.

AMERICAN INDIAN UNEMPLOYMENT: Annual Average Unemployment Rates on Montana's Reservations

Reservations	2009
Blackfeet	13.8%
Crow	10.5%
Flathead	8.5%
Fort Belknap	Unavailable
Fort Peck	8.8%
Northern Cheyenne	14.0%
Rocky Boy's	16.3%

FACTORS IMPACTING THE MCH POPULATION

ORAL HEALTH: Eleven Montana Community Health Centers (Billings, Bozeman, Bullhook, Butte, Cutbank, Great Falls, Helena, Kalispell, Livingston, Missoula and Libby) include some dental services, though the waiting lists can be long.

Indian Health Service offers dental clinics in:

Browning (Blackfeet Service Unit [SU])	satellite in Heart Butte
Crow Agency (Crow SU)	satellites in Lodge Grass & Pryor
Lame Deer (Northern Cheyenne SU)	
Harlem (Fort Belknap SU)	satellite in Hayes
Poplar (Fort Peck SU)	satellite in Wolf Point
Tribal Programs:	
Box Elder (Rocky Boy SU)	
Polson (Flathead SU)	satellites in Pablo & St. Ignatius

Montana's point-in-time Pregnancy Risk Assessment Monitoring System (PRAMS) in 2002 reiterated lack of access to dental care for pregnant Medicaid participants as a statewide problem. In 2009, 11 counties did not have a dentist and 15 (including the 11) did not have a dentist that accepted Medicaid. Oral health results from a statewide convenience sample of third graders for 2002-2004 suggested immediate caries were a problem for 25.1% of the sample, with a past caries rate of 50.7%, and an urgent caries rate of 6.2%.

IMMUNIZATIONS: In 2008, Montana had a 66% immunization rate for children aged 19-35 months who were fully immunized. In 2008, Montana ranked 50th in the nation for series of immunizations given to 19-35 month old children.

MORTALITY: (Rankings: 1=low, 51=high)
High mortality rates are a problem for Montana.

Infant Mortality	
2004-2006:	6.0 per 1,000 live births

Death Rate for children aged 1-14 years

2006: 772.9 per 100,000

Five leading causes of death for MT children aged 1-14 years (2006):
1. unintentional injury (32.7%)
2. malignant neoplasms (14.3%)
3. homicide (6.1%)
4. congenital anomalies (4.1%)
5. suicide (4.1%), all others (38.8%)

Five leading causes of death for MT American Indian children aged 1-14 (2006):
1. unintentional injury (40%)
2. malignant neoplasms (20%)
3. suicide (20%)
4. all others (20%)
5. none listed

Death Rate for Total Population (all ages)
2006: 30 per 100,000

Five leading causes of death for total MT population (2006):
1. malignant neoplasms (22.9%)
2. heart disease (22.1%)
3. chronic low respiratory disease (6.8%)
4. unintentional injury (6.6%)
5. cerebrovascular (5.4%)
6. all others (36.1%)

Five leading causes of death for MT American Indian population--all ages (2006):
1. malignant neoplasms (19.9%)
2. heart disease (13.9)
3. unintentional injury (12.9%)
4. liver disease (6.1%)
5. diabetes mellitus (5.3%)
6. all others (41.8%)

In 2006, Montana had a suicide death rate of 19.7 per 100,000 in population.

CHILDREN & YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN): Montana had an estimated 27,853 children/youth with special health care needs in 2006, up somewhat from an estimated 26,981 in 2001. Examples of conditions that qualify children with special health needs in Montana are: cystic fibrosis, diabetes, cleft lip/palate, asthma, seizure disorder, and juvenile idiopathic arthritis. CYSHCN in Montana may be eligible to receive services from Children's Special Health Services (CSHS), DPHHS. The program's mission is to develop and support systems of care for CYSHCN. The following services are available to eligible CYSHCN and their families: pediatric specialty clinic services, financial assistance, and/or resource referrals. CSHS does not receive any general funds from the state of Montana, it is funded by the Maternal and Child Health Block Grant and revenue received from billing 26 health care agencies for three interdisciplinary clinics (cleft/craniofacial, metabolic and cystic fibrosis).

Effective January of 2008, all newborns are tested for hearing and the 28 conditions recommended by the American Academy of Pediatrics and the American College of Medical Genetics. The metabolic/bloodspot screen follow-up is a contracted service managed by CSHS. The newborn hearing screening program is managed by a staff member in CSHS. This staff person conducts on-site reviews for quality assurance and is continually assessing the needs of the families and partners of the newborn hearing program.

TOBACCO USE, MONTANA YOUTH:
In 2005, Montana introduced the Clean Indoor Air Act (CIAA) that was passed by the state legislature that required schools to be tobacco-free and public places to be smoke-free. The CIAA was fully implemented in October 1, 2009.
In 2009, 12% of high school youth who tried cigarettes before the age of 13, a 10% percentage point decrease from 2001 (29%). During 2009, the highest prevalence was reported for 9th grade students (18%) with the lowest prevalence reported for 12th grade students (8%) who tried cigarettes before the age of 13. Statewide, 50% of high school students had ever tried cigarette smoking (even one of two puffs) during 2009. The prevalence of high school youth who smoked cigarettes on at least one day during the past month decreased from 29% in 2001 to 19% in 2009. Cigarette use was more prevalent among females (20%) than males (18%) during 2009. The use of smokeless tobacco (e.g., chewing, sniffling, or dipping) among high school students decreased only slightly between from 16% in 2001 to 15% in 2009. In 2009, the use of smokeless tobacco was more prevalent among high school boys (24%) than high school girls (4%). In 2009, 55% of high school current smokers had tried to quit smoking cigarettes during the past 12 months.

In 2006, 38% of Montanans were aware that secondhand smoke is a risk factor for SIDS. In 2008, 97% of adults were aware that breathing secondhand tobacco smoke causes respiratory problems in children. Approximately 12% of Montana households with children permitted smoking at any time or any place in the home during 2008. In 2007, 30% of Montana children aged 12 to 17 years who lived in households where someone uses tobacco compared to 28% in 2003. Thirty-three percent of Montana high school students reported being in a car with someone who was smoking in 2008.

OBESITY: In 2007, 12% of Montana children aged 10-17 were obese compared to the national average of 16%. The obesity prevalence among Montana Youth increased over the past several years. The prevalence of obesity among Montana high school students increased significantly from 6% in 1999 to 10% in 2009. In 2009, high school girls had a lower prevalence of obesity (8%) compared to high school boys (13%). In 209, 24% of Montana adults were obese compared to the national average of 27%. The prevalence of obesity among Montana adults increased from 16% in 1999 to 24% in 2009. In 2009, females had a slightly lower prevalence of obesity (23%) compared to males (24%).

HEALTH CARE ACCESS
One Montana Critical Access Hospital CEO always began medical provider recruiting conversations with, "Our town is 70 miles from the nearest McDonald's, 90 miles from the nearest WalMart and 200 miles from the nearest shopping center. Can you handle that?" This description of an isolated Montana community is not unusual. A former Montana U.S. Senator put it this way, "There's a lot of dirt between light bulbs in Montana." Geographic isolation and the long distance between towns and healthcare organizations are often barriers to healthcare access in Montana.

Fifty-four percent of Montanans travel more than 5 miles (one way) to get to a doctor's office; 13% travel more than 30 miles; 7% travel more than 50 miles.

TRANSPORTATION: Vast distances, isolation of small communities, sparsely located ranches and farms, as well as severe winter weather can make travel extremely difficult and often dangerous, especially over icy mountain passes or through ground blizzards on the plains. Public transportation is limited, with many areas in the state totally devoid of air, rail, or bus transportation. With little or no public transportation available in Montana's many isolated, rural communities, access to local primary care as well as out-of-town specialty medical services can be a problem. Nearly 96% of Montanans drive themselves or get a ride from a friend when traveling to a doctor's office; fewer than 1% use public transportation (probably because public transportation is found primarily in urban areas and most of Montana is frontier or rural).

INCOME: Montana's lower-than-the-national-average median income adversely affects the ability of many Montanans to pay for medical care. This is reflected in the 19.1% of Montana's population (nearly 180,000 people) without health insurance.

In a 2003 survey, 12.9% of Montana's adults reported they could not see a doctor in the previous 12 months because of the cost. Examining the survey a little closer, over a quarter (26.3%) of all Montana adults ages 18-64 with a disability--a population that probably needs to see a doctor regularly--had not seen a doctor in the previous 12 months because of cost. Also, over one-quarter (26.7%) of Montanans do not have a personal doctor or health care provider.

AVAILABILITY OF SERVICES: There are ongoing efforts towards the improvement of the availability of an access to health services in Montana. Montana has 45 Critical Access Hospitals, 17 hospitals, 46 rural health clinics, and 37 federally qualified health centers. There are also 56 local county public health health departments and 88 nursing home facilities in Montana. The state has 2353 licensed physicians, 599 active licensed dentists, and 81 psychiatrists.

Healthcare for American Indian residents of Montana is provided by a network of services including: Indian Health Service, hospitals/clinics, county health departments; and private health services. There are three urban Indian full-service medical clinics located in Billings, Great Falls, and Helena and two referral based clinics in Missoula and Butte.

Because of its large geographic size and small population, Montana has 4.3 hospital beds per 1,000 people, ranking near the high end (47th out of 51) in beds-per-1,000-population compared to the 50 states and District of Columbia. However, Montana ranks low (19th out of 51) with 113 hospital admissions per 1,000 people. Montana ranks on the low end (40th out of 51) in the number of nursing homes in the state (again, because of its small population) and 44th out of 51 in the number of nursing home residents.
Although Montana has 76 home health agencies statewide, home health services are not available in 8 of Montana's 56 counties.

HEALTH INSURANCE: According to 2004 Center for Forensic Economic Studies (CFES) data, Montana ranked 50th in the nation for employer-provided insurance. Low-income children and low-income parents consisted of 19.8% and 82.3% of the population for 2004, respectively. CFES gave Montana an "F" in health care for these reasons. The Bureau of Business and Economic Research of the University of Montana is studying the incidence of uninsured status in Montana and on June 25, 2003, reported the following for the Montana population under age 65: 43% of urban and 57% of rural residents are uninsured; 31% to 45% of American Indian residents are uninsured, while 18%-22% of Whites and all others lack health insurance. Most of the businesses in Montana are small businesses and cannot afford health insurance premiums for their employees. Agricultural families are often disqualified from public programs because of high assets, even with low income, and cannot pool for reduced premiums. Three-year cumulative average for people without health insurance coverage was 16.1% for 2001-2003. Montana ranked 6th in the nation for hospital expenses per inpatient day at $2,573. In 2003, Montana had 47,088 enrollees in Health Maintenance Organizations (HMO) in 2003, down from 2002.

In November 2008, Montana voters approved the new Healthy Montana Kids program, which expanded coverage under Medicaid and CHIP by raising eligibility levels to 133 percent and 250 percent of the federal poverty line, respectively. The expansion, which went into effect in October 2009, will cover as many as 29,000 of the 34,000 underinsured children in the state.

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) STATUS 2010:
Montana continues to face a health care worker shortage. Since 2004, Montana has witnessed a net increase in the number of shortage designations. The active HPSA designations in Montana are:

Number of HPSA's in Montana

HPSA Type	2004	2007	2010
Primary Care	57	90	99
Dental Health	42	56	60
Mental Health	35	49	55

As of January 2010, Health Professional Shortage Areas, which included HPSA facilities, were located in all or parts of Montana's 56 Counties as follows:

- Primary Care: 55 out of 56 counties (98%)
- Dental Health: 48 of 56 counties (85%)
- Mental Health: 56 of 56 counties are designated all or in part as a shortage area.

CONCLUSION: As Montana's population continues to age, demand for all occupations -- including those that are now adequately staffed will rise dramatically while the health care workforce diminishes. The impact will be felt more dramatically in Montana than in most other states because of its older-than-average population.

Montana's Title V Program provides leadership and direction for state and local programs and partners to identify issues affecting the health of Montana's MCH population. The 2010 Needs Assessment resulted in the establishment of six Priority Areas and seven new State Performance Measures to better address the current needs of the MCH population. Montana's aging population, geographic challenges, and access to care issues all pose unique challenges to health care delivery for the MCH population. In some counties, local health departments are the sole source of health care for the surrounding population. Montana's Title V funds, which directly support the local health departments in 54 of 56 counties, are critical to meeting the public health needs of the MCH population across the state.

REFERENCES

State of Montana. CECRA Priority Sites Sorted by Site [Web Page]. http://www.deq.mt.gov/StateSuperfund/PDFs/CecraListBySite.pdf Updated January 26, 2010. Accessed April 16, 2010.

U.S. Census Bureau. State & County QuickFacts [Web page]. http://quickfacts.census.gov/qfd/states/30000.html Accessed May 2, 2010.

U.S. Census Bureau. State & County QuickFacts: Estimates for Montana Counties [Web page]. http://quickfacts.census.gov/qfd/states/30000lk.html Accessed May 2, 2010.

U.S. Census Bureau. State & County QuickFacts: Population Projections to 2030 [Web page]. http://www.census.gov/population/projections/SummaryTabA1.pdf Accessed May 2, 2010.

U.S. Census Bureau. State & County QuickFacts: Population Projections to 2030 [Web page]. http://www.census.gov/population/projections/SummaryTabA1.pdf Accessed May 2, 2010.

http://factfinder.census.gov/servlet/GRTTable?_bm=y&-_source=mdr&-geo_id=01000US&-_col=disp_order&-ds_name=ACS_2005_EST_G00_&-_lang=en&-redoLog=false&-mt_name=ACS_2005_EST_G00_R0101_US30&-format=US-30

U.S. Census Bureau. State & County QuickFacts: Population Projections to 2030 [Web page]. http://www.census.gov/population/projections/SummaryTabA1.pdf Accessed May 2, 2010.

U.S. Department of Education, Institute of Education Sciences. National Center for Educational Statistics: Public High School Graduation Rates by State [Web page]. http://nces.ed.gov/programs/coe/2009/section3/indicator19.asp Accessed May 1, 2010.

U.S. Department of Education, Institute of Education Sciences. National Center for Educational Statistics: State Profiles [Web page]. http://nces.ed.gov/nationsreportcard/states/ Accessed May 1, 2010.

U.S. Census Bureau. State & County QuickFacts [Web page]. http://quickfacts.census.gov/qfd/states/30000.html Accessed May 2, 2010.

State of Montana, Department of Public Health and Human Services. Natality [Web page].

http://www.dphhs.mt.gov/statisticalinformation/vitalstats/2008report/08birth.pdf#fig1 Accessed May 1, 2010.

State of Montana, Department of Public Health and Human Services. Natality [Web page]. http://www.dphhs.mt.gov/statisticalinformation/vitalstats/2008report/08birth.pdf#fig1 Accessed May 1, 2010

2008 Quarterly Census of Employment and Wages, U.S. Bureau of Labor Statistics

Tax Foundation. Tax Data, Charts, and Maps [Webpage]. http://www.taxfoundation.org/taxdata/topic/40.html Accessed May 3, 2010.

Montana State University. Montana's Poverty Report Card [Webpage]. http://www.montana.edu/extensionecon/poverty.html Updated June 2009. Accessed May 3, 2010.

Montana State University. Montana's Poverty Report Card [Webpage]. http://www.montana.edu/extensionecon/poverty.html Updated June 2009. Accessed May 3, 2010.

State of Montana, Tribal Reports and Data. Economic Status of American Indians in Montana: A Preliminary Assessment [Webpage]. http://tribalnations.mt.gov/trreports.asp Updated Winter 2004. Accessed April 30, 2010.

United States Department of Labor, Bureau of Labor Statistics. Unemployment Rates for States [Webpage]. http://www.bls.gov/lau/lastrk09.htm Accessed May 4, 2010.

State of Montana. Montana Reservation Labor Force Statistics 2008 Annual [Webpage]. http://www.ourfactsyourfuture.org/cgi/databrowsing/?PAGEID=4&SUBID=220 Accessed May 4, 2010.

The Henry J. Kaiser Family Foundation. State Health Facts [Webpage]. http://www.statehealthfacts.kff.org/comparemaptable.jsp?ind=54&cat=2 Accessed May 6, 2010.

The Henry J. Kaiser Family Foundation. State Health Facts [Webpage]. http://www.statehealthfacts.kff.org/comparemaptable.jsp?ind=667&cat=2 Accessed May 6, 2010.

Centers for Disease Control. National Center for Injury Prevention and Control [Webpage]. http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html Accessed May 6, 2010.

The Henry J. Kaiser Family Foundation. State Health Facts [Webpage]. http://www.statehealthfacts.kff.org/comparemaptable.jsp?ind=667&cat=2 Accessed May 6, 2010.

Health Resources and Services Administration: The National Survey of Children with Special Health Care Needs 2005-2006 [Webpage]. http://mchb.hrsa.gov/cshcn05/SD/montana.htm Accessed June 30, 2010.

Tobacco Free Montana. Trends in Youth Tobacco Use and Attitudes 2000-2006 [Webpage]. http://tobaccofree.mt.gov/publications/youthtrends20002006.pdf Accessed May 7, 2010.

From Larry Putnam, retired CEO, Phillips County Medical Center, Malta, Montana

Senator Conrad Burns, U.S. Senate Floor, December 8, 2004

2005 BRFSS Data: State Added Question, "Travel Access To Health Provider"

Ibid.

2004 BRFSS Data

Ibid.

See "Beds per 1,000 population" table, The Henry J. Kaiser Family Foundation. http://www.statehealthfacts.org/comparetable.jsp?ind=396&cat=8&sub=95&yr=1&typ=1&sort=1238

See "Admissions per 1,000 population" table, The Henry J. Kaiser Family Foundation. http://www.statehealthfacts.org/comparetable.jsp?ind=398&cat=8&sub=95&yr=1&typ=1&sort=1238

See "Total Number of Certified Nursing Facilities, 2006", The Henry J. Kaiser Family

Foundation.
http://statehealthfacts.org/comparetable.jsp?ind=411&cat=8&sub=97&yr=17&typ=1&sort=n&o=d

See "Total Number of Residents in Certified Nursing Facilities, 2006", The Henry J. Kaiser Family foundation.
http://statehealthfacts.org/comparetable.jsp?ind=408&cat=8&sub=97&yr=17&typ=1&o=d&sort=n

From 2004 Montana County Health Profiles. See http://nris.mt.gov/epht/hra.aspx?county=30000&year=2004. The eight counties without home health services are Big Horn, Carter, Golden Valley, Musselshell, Petroleum, Treasure, Valley and Wheatland.

An attachment is included in this section.

B. Agency Capacity

Montana's Title V programs are located in the Department of Public Health and Human Services (DPHHS), the largest agency of Montana's state government, with a biennial budget of about $3 billion. DPHHS has 3,100 employees across the state of Montana, 2,500 contracts and 150 health programs. The programs are housed in one of the 11 divisions of DPHHS. The Title V Program is housed in the Family and Community Health Bureau (FCHB) which is within the Public Health and Safety Division (PHSD), one of the 11 divisions of DPHSS. The FCHB is charged with the responsibility of administrative oversight of the Title V Maternal and Child Health Block Grant (MCH BG). This responsibility includes developing and sustaining collaborative public and private partnerships for the purposes of providing maternal and child health care services to Montana's MCH population across Montana's 145,552 square miles, 56 counties, and 7 Native American reservations.

Statutory Authority for Maternal and Child Health (MCH) Services are found in the Montana Codes Annotated (MCA 50-1-2020). General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); acceptance and expenditure of federal funds available for public health services; and use of local health department personnel to assist in the administration of laws relating to public health. Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) and Fetal, Infant, Child, Mortality Review (FICMR) are authorized in Title 50.

Rules implementing the above authority are found in Titles 16 and 46 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including children with special health care needs, family planning, school health, and the rules authorizing case management for high risk pregnant women.

The FCHB has a role in ensuring that services and programs to support healthy growth and development are available and accessible to Montana's MCH population. The Bureau budget includes 13 funding sources, of which approximately 96% is federal funding and the remaining 4% is state general fund. The three largest funding sources are from the United States Department of Agriculture for WIC Administration and Supplemental Food; the Department of Health and Human Services Maternal and Child Health Block Grant; and the Office of Population Affairs Title X Family Planning. Additional federal grants, earmarked for specific programs benefitting the MCH population, round out the FCHB yearly operating budget.

Montana's economic situation is similar to that of the other states: a decline in state revenue has resulted in budget cuts for programs allocated state general dollars. The decline in state general revenue as well as the loss of federal funding to support programs (such as the coordinated school health program, the birth defects registry from CDC, the oral health program from HRSA,

and the fetal alcohol spectrum disorder prevention program funding from SAMHSA) contributed to diminished FCHB staff and a subsequent reorganization. In May, 2010 the Infant Child Maternal Health Section was combined with the Maternal Child Health Coordination Section, decreasing the number of supervisory staff by one. The Primary Care Office, Public Health Home Visiting Program, FICMR and Targeted Case Management support functions were moved along with 2.5 FTE staff positions into the MCHC Section. In addition, PHSD leadership created an office of Epidemiology and Scientific Support, which will be led by the State Epidemiologist who is presently being recruited. One of the two MCH epidemiologists is moving to the new office of Epidemiology and Scientific Support. The remaining MCH epidemiologist will continue to focus on MCH issues.

As of May 2010, the 36 staff members of FCHB are organized into four sections, one unit, and one office:

- Maternal Child Health Coordination Section (MCHC),
- Children with Special Health Services Section (CSHS),
- WIC Nutrition Section (WIC),
- Women's and Men's Health Section (WMH),
- MCH Epidemiology Unit, and the
- Primary Care Office.

The FCHB is responsible for coordinating the ongoing MCH Needs Assessment process. Included with this application, is Montana's 2010 MCH Needs Assessment, which is a culmination of the past five years of numerous meetings with public and private partners; gathering qualitative and quantitative data; analyzing the data; identifying MCH priority needs, (as well as emerging needs); assessing the State's current resources, activities, and services; and developing state performance measures based on the FCHB's capacity to provide direct health care services, population based services, enabling services, and infrastructure-building services.

In addition to ensuring the ongoing work on the MCH Needs Assessment, each FCHB section fulfills a role as related to the requirements for receiving the MCH BG. As illustrated on the Agency Capacity Attachment, each section maintains numerous partnerships with public and private entities, which provide preventive and primary care services to the MCH population.

The MCHC Section's primary partners for MCH services are Montana's county health departments. Montana's MCH Administrative Rules of Montana (ARM 37.57.1001) do not require county health departments to accept the MCH Block Grant funding, they can choose to not participate. In FY 2010, 54 of Montana's 56 county health departments accepted MCH funding with the intent of providing MCH services to their populations; two counties opted to not contract with the state to provide MCH services. As part of their contractual obligations, the contracted county health departments select one national or state performance which will be their primary MCH focus. Approximately 42% of the state's MCH BG allocation is distributed to the local health departments.

The MCHC Section also houses the Public Health Home Visiting (PHHV)/ Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Program. The PHHV program is part of the MIAMI act passed by the Montana legislature in 1989. The Legislature has continued to support the PHHV/MIAMI Program with general funds and tobacco trust settlement moneys. The goals of the MIAMI legislation compliment the charges in Title V of the Social Security Act, which are to: 1) ensure that mothers and children, particularly those with low income or with limited availability of health services, have access to quality maternal and child health services; 2) reduce the incidence of infant mortality and the number of low birth weight babies; and 3) prevent the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care.

The PHHV/MIAMI Program has continued to evolve to meet the needs of the MCH population. In Fiscal Year 2010, 14 county health and two tribal health departments provided PHHV services by

using a team consisting of a public health nurse, social worker, and dietitian, to provide support and guidance to families who may not be able to access services. Most recently, the PHHV/MIAMI contractors and FCHB staff completed a PHHV reassessment collaborative process whereby changes were recommended to the program requirements. For Fiscal Year 2011, the PHHV/MIAMI contractors will be required to address four outcome measures, which are directly related to the MCH BG: 1) increase the percent of PHHV clients served by the PHHV program who receive adequate prenatal care as measured by the Kotelchuck Index; 2) increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy; 3) increase the percentage of PHHV infants who are born at a healthy birth weight (2500 to 4000 grams); and 4) increase the percentage of eligible PHHV infants who are exclusively breastfed through 6 months of age.

The FCHB has been selected to provide the leadership and administrative oversight for the state's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program grant applications. Phase I was submitted on July 9, 2010. and Phase II will be submitted on September 20, 2010. The Bureau has engaged in several stakeholder meetings with the Directors of Montana's agency for Child Abuse Prevention and Treatment, Substance Abuse Services, Head Start State Collaboration Office, and Early Childhood Services as well as with other interested stakeholders that are currently providing home visiting services. These meetings have aided in the state's Phase II application and have laid the foundation for the final phase of implementing the ACA Home Visiting grant in Montana.

The Fetal, Infant and Child Mortality Review Program (FICMR) is also housed in the MCHC Section. FICMR is a statewide effort to reduce preventable fetal, infant and child deaths by making recommendations based on multidisciplinary reviews of the deaths. These in-depth reviews bring together a variety of information from many sources and provide a venue for communities to recognize system shortcomings and create strategies to improve these systems. The prevention of fetal, infant, and child deaths is both the policy of the state of Montana and a community responsibility that was authorized in statute (MCA 50-19-401 through 50-19-406) in 1997. The FICMR process identifies critical community strengths and weaknesses as well as unique health/social issues associated with poor outcomes. In 2005-2006, 53 of Montana's 56 counties and all 7 Indian Reservations participated in FICMR reviews through 30 local FICMR teams. To date, 89% of fetal, infant and child deaths in Montana in 2005-2006 have been reviewed by local teams. A biennial report is prepared and distributed to policy makers. Policy makers review preventable deaths and strategize at community and state levels on how to address FICMR related issues.

To the extent resources allow, the MCHC also addresses the MCH population's oral health needs. One of the two MCHC Health Education Specialists oversees the Open Wide Program, a free online training program initially developed by the National Maternal & Child Health Resource Center, which is accessible to providers who work with the MCH population, i.e. Head Start and child care providers; WIC; public health departments; and school nurses. Montana's Oral Health Education guide was recently highlighted in the National Maternal & Child Health Resource Center, March 2010, Oral Health Resource Bulletin.
The MCHC Supervisor collaborates with the Early Childhood Services Bureau (ECSB), housed in the Human and Community Services Division, who administers the Early Childhood Comprehensive Systems Initiative Grant (ECCS). The ECCS Grant has supported the development and training on a Parent Education and Leadership Curriculum; implementing an early childhood mental health consultation model in child care programs; and ongoing support for 18 Community School Readiness Teams. The MCHC Section also ensures the collaborations and partnerships for addressing those national performance measures which are housed in other Departments. These partnerships include working with the State's Suicide Prevention Coordinator, the Injury Prevention and Immunization Sections, and Healthy MT Kids which operates the MCH toll-free line.

Montana's Children and Youth with Special Health Care Needs (CYSHCN) and their families are

served by a number of programs that emanate from the Children's Special Health Services (CSHS) Section, which rejoined the FCHB in January, 2006. Prior to 2006, CSHS was located in the Health Care Resources Bureau of the Health Resources Division. Montana is unique in that blind and disabled individuals, under the age of 16 are automatically eligible for benefits under Title XVI. These individuals are also eligible to receive CSHS services.

Data taken from Montana's 2004 - 2008 MCH Block Grant Annual Reports indicates an average of 4,698 CYSHCN received services from a number of programs overseen by the CSHS. CSHS is responsible for system development and service support for children and youth with special health care needs and their families. This section provides regional clinics, direct pay programs, the newborn hearing and metabolic screening programs, and coordination of the state's genetics program.
CSHS works closely with three Regional Pediatric Specialty Clinics (RPSC) which provide medical care for CYSHCN. The RPSC are in Great Falls, Missoula, and Billings, and outreach clinics are conducted in Bozeman, Helena, and Kalispell as well as on two reservations: Wolf Point and Browning. There are three interdisciplinary clinics: cleft/craniofacial, cystic fibrosis and metabolic. The pediatric specialty clinics vary by region, but include: endocrine, genetics, gastrointestinal, hemophilia, high risk infant, muscular dystrophy, neural tube defect, orthopedic, pulmonary, rehabilitation, and rheumatology.

The Newborn Hearing and Metabolic Screening Program and the Birth Defects Registry was moved to the CSHS section in spring of 2006, in order to promote and coordinate clinical follow up and tracking. CSHS continues to support the development of Children's Health Referral and Information System (CHRIS), a data collection system that is interconnected with the RPSC, MT School for the Deaf and Blind, the MT Medical Genetics program, Healthy MT Kids, Social Security Disability, neonatal intensive-care unit (NICU) referrals, outreach specialty providers and others.

January 2008 witnessed the beginning of the implementation of mandated screening of all Montana newborns for 29 conditions as recommended by national screening standards. CSHS has developed and maintained a partnership with the Department's Laboratory Services Bureau which houses the Newborn Screening Coordinator position. CSHS continues to provide the leadership and administrative oversight of the Newborn Screening Follow-Up Program which is contracted with Shodair Children's Hospital.

Throughout the years, the CSHS staff has focused their efforts to secure Healthy MT Kids (formerly known as CHIP) and Healthy MT Kids Plus (formerly known as Medicaid), and private insurance payments for services provided at their regional clinics, with the revenue being reinvested in the CSHS programs and services. A portion of these funds is used to ensure that patients who are uninsured or under-insured are able to attend the interdisciplinary clinics and that they are not charged. CSHS does not collect co-pays or deductibles from patients attending CSHS interdisciplinary clinics.

CSHS continues to foster relationships with non-profit organizations dedicated to children's issues. Their work with Parents Lets Unite for Kids (PLUK), a longstanding advocate for parents and families and the host organization for Montana's Family Voices chapter, centers on collaboration to improve access to community-based, family-centered services for CYSHCN. CSHS also works closely with the entity providing Part C Services, the School for the Deaf and Blind, Social Security Disability, NICUs, school nurses, Vocation Rehabilitation, and the chronic disease program within DPHHS. CSHS also works with case managers from hospitals (in and out of state), insurance companies, and counties.

The FCHB is home to the state's Title X Agency, the Women's and Men's Health Section (WMH) that has historically received a small portion of MCH Block Grant funds to support their partnerships with 14 Delegate Agencies (DA) offering family planning services in 28 locations serving all 56 counties. WMH is responsible for family planning services through Title X supported

clinics across the state. The section also monitors and supports community based efforts to prevent teen and other unintended pregnancies.

In FY 2011, WMH will receive $10,000 for their distribution to the DAs for their efforts aimed at preventing teen pregnancies. The DAs provide reproductive health services, technical assistance, and educational and outreach materials targeting low income women and men, including adolescents.

The DAs are also a designated Sexually Transmitted Disease (STD) Program working closely with the Division's STD/HIV Prevention Section. Additionally, each DA is required to employ a medical service provider who provides comprehensive breast and cervical screening services to an identified target population, as well as provide referral services to other programs, i.e. WIC.

Also housed in the FCHB is Montana's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Section. WIC administers the WIC program in Montana, which offers services through 27 Regional Program contracts with Public Health Departments, hospitals, private non-profits, and tribal organizations with related health or social service programs providing services for all counties in Montana. In 2007, an average of 21, 000 participants per month were provided nutrition assessment and education to improve their eating behaviors; referrals to other health care and social service programs; access to a supplemental food package which now includes fresh fruits and vegetables; and breastfeeding encouragement.

Beginning in 2009, WIC has been involved with developing, implementing, and offering training on MSPIRIT, a new MIS (management implementation system for WIC). It is anticipated that MSPIRIT will provide enhanced data as to the numbers of women initiating breastfeeding, as well as continuing to breastfeed at six months of age and beyond as MSPIRIT links the breastfeeding dyad and food packages being issued. MSPIRIT will also provide data as to the usage of Montana's new WIC Food Package that was rolled out in November 2009. WIC is also the lead for breastfeeding promotion programs through their oversight of the Breastfeeding Peer Counselor Projects (BPCP). Nine Montana communities were funded and operated throughout the year as a BPCP.

WIC also supports the USDA WIC Farmer's Market Nutrition Program (FMNP), which has been operating in Montana since 2002. FMNP participants receive nutrition education related to fruits and vegetables. The nutrition education includes information on selecting, preparing, best time to buy and nutritional value of fruits and vegetables, and the value of physical activity for a family by shopping at their local farmers' market. In 2007, there were seven local WIC programs participating in FMNP: Custer, Flathead, Lewis and Clark, Missoula, Ravalli, Valley and Yellowstone. The WIC FMNP benefits allow participants to purchase locally grown fresh fruits and vegetables. A total of 5,354 women and children were provided the benefit of $16 in FMNP checks for the market season. Participant and farmer responses to the program have been positive.

The MCH Epidemiology Unit, responsible for overseeing the State System Development Initiative (SSDI) grant, overseeing the 2010 MCH Block Grant Needs Assessment, and submitting the FCHB's Graduate Student Internship Program application, is integral to the FCHB. As mentioned earlier, the PHSD reorganization, upon the hiring of the state Epidemiologist, will result in the present Epidemiology Unit housing the lead MCH Epidemiologist and the FCHB Data Coordinator. Both these positions work closely with the four sections advising on and conducting epidemiological analyses and evaluation projects for the programs administered by the sections. The Epidemiology Unit provides key services for additional grant opportunities that are submitted by the FCHB, and will be a key player in the state's ACA Home Visiting application.

The Primary Care Office (PCO) was incorporated into the MCHC Section in 2009, but continues to operate as a unique program within the Bureau. The Primary Care Office's responsibilities focus on facilitating federal designation of health professional shortage areas, and supporting recruitment efforts for primary care, oral health and mental health professionals. The PCO

compliments the efforts of the Bureau staff to promote and support access to quality health care for the MCH population in the state. The PCO and Epidemiology Units provided critical data for the state's April 2010 Grants to States to Support Oral Health Workforce Activities, that if funded will move Montana forward by hiring an external evaluator to perform a thorough assessment of the oral health status and needs of the state and expand the MT Area Health Education Center (AHEC) dental recruitment and retention program.

Maternal and child health services are funded not only by the MCH Block Grant distributed to counties, but by local funding, fees and donations and through programs supported with state general funds. As reported in Montana's MCH BG Annual Reports for 2004 - 2009, direct health care, enabling, population based, and infrastructure services were provided to an average of 97,007 clients per year. As reported in Montana's MCH Block Grant 2008 Annual Report, state funding for genetics, home visiting, and newborn screening follow up resulted in a total state match of $2,173,902. In addition, local partners, primarily local health departments, provided additional match of $3,500,746, and program income (including state and local billing and donations) which totaled $914,508. These amounts, combined with the 2008 federal allocation of $2,462,222 totaled $9,051,378 for MCH Services.

The MCH Block Grant data collected by the FCHB indicates that Montana continues to spend the largest portion of funding on children's services, primarily through contracts with local agencies that in turn provide preventive and primary care services for pregnant women, mothers, infants, and children. The local contractors provide:

- Enabling services, such as health education; family support; assistance with enrollment into Healthy MT Kids or Healthy MT Kids Plus (formerly CHIP and Medicaid); and case management;
- Population-based services such as newborn screening and neonatal follow-up; oral health education; public education on preventable deaths; and immunizations; and
- Infrastructure services such as technical assistance for developing standards of care, evaluation procedures, and policy development; and training opportunities at the annual DPHHS Spring Public Health Conference.

The CSHS programs and services for CYSHCN expend 30% of the MCH Block Grant. These services are primarily direct health care services such as the medical services provided at the Regional Pediatric Specialty Clinics and the purchase of medical equipment not covered by insurance.

The Governor's Office provides an annual Tribal Relations Training for state employees to strengthen government-to-government relationships and to ensure that participants have a better understanding of state-tribal policies and principles to integrate into their day-to-day work with tribal governments and people. All FCHB Section Supervisors, as well as several other FCHB staff, have attended this training in the last three years. Recently, the Governor's Office also developed an online training program, designed by the federal government, entitled "Working Effectively with Tribal Governments." The training curriculum has been developed to provide government employees with skills and knowledge they can use to work more effectively with tribal governments.

The FCHB organizes and promotes a yearly Spring Public Health Conference. The planning committee has made it a priority for the opening ceremony to be provided by one of the seven Native American tribes in Montana. The Conference also strives to include at least one breakout session which focuses on health concerns associated with Native Americans.

The role of the Health Resources Division (HRD) is to provide health care for low-income and disabled Montanans through Medicaid and the Healthy Montana Kids (HMK) Plan. The HRD provides administration, policy development, and reimbursement for the primary and acute care portions of the Medicaid program. It also provides children's mental health services and health insurance coverage for children through CHIP.

The FCHB's vision is to promote high quality health care services that are delivered in a respectful manner; promote healthy and safe Montana environments (family homes, child care facilities, schools, and communities), and reduce health care disparities within the state. Its mission is "to promote and improve the health and safety of Montana's women, men, children, and families." The FCHB is able to achieve its vision and mission through its ongoing administration of the Maternal Child Health Block Grant and the much needed services this funding provides to the state's maternal child health population.

An attachment is included in this section.

C. Organizational Structure

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the programs and services, which safeguard the health and welfare of Montanans. The department mission is "improving and protecting the health well-being and self reliance of all Montanans." The Director of the Department is Anna Whiting Sorrell, who was appointed by Governor Brian Schweitzer in November 2008. She oversees the agency's 3,100 employees, 2,500 contracts and 150 programs. DPHHS is the largest agency of state government, with a biennial budget of about $3 billion.

The Department of Public Health and Human Services (DPHHS) is a "mega agency" encompassing health and human services for the state of Montana. The Department is organized into the Director's Office and 11 divisions. The Director's Office includes offices responsible for legal affairs, human resources, public information, planning and analysis.

The rest of the Department is organized into 11 divisions:

- Addictive & Mental Disorders -- Develops and implements a statewide system of prevention, treatment, care, and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol.
- Business & Financial Services - Provides professional services for the management of the Montana Department of Public Health and Human Services.
- Child & Family Services -- Provides services to protect children who have been or are at substantial risk of abuse, neglect or abandonment.
- Child Support Enforcement - Pursues and finances medical support of children by establishing, enforcing, and increasing public awareness of parental obligations.
- Developmental Services - Contracts with private, non-profit corporations to provide services for individuals, and their families, who have developmental disabilities.
- Health Resources - Provides health care for low-income and disabled Montanans through Medicaid and the Healthy Montana Kids (HMK) Plan.
- Human & Community Services - Provides cash assistance, employment training, supplemental nutrition assistance (formerly food stamps), Medicaid, child care, meal reimbursement, nutrition training, energy assistance, weatherization, and other services for needy families.
- Quality Assurance - Monitors and ensures the integrity and cost-effectiveness of programs administered by the department.
- Senior & Long Term Care - Provides information, education, and high quality, cost effective long-term care services for the elderly and disabled.
- Technology Services - Provides operational and technical support to department programs.
- Public Health & Safety -- see below

Jane Smilie is the administrator of the Public Health and Safety Division. The Public Health & Safety Division (PHSD) oversees the coordination of the public health system in Montana. The state's public health system is a complex, multi-faceted enterprise, including partners such as the City/County Health Departments, private medical providers and hospitals, local Emergency

Medical Services, Emergency Management agencies and other units of local government. The Division is organized into five bureaus:

- Chronic Disease Prevention & Health Promotion Bureau - Todd Harwell, Bureau Chief
- Communicable Disease & Prevention Bureau -- Jim Murphy, Bureau Chief
- Financial Operations and Support Services Bureau - Dale McBride, Bureau Chief
- Laboratory Services Bureau - Anne Weber , Bureau Chief
- Family and Community Health Bureau -- Jo Ann Dotson, Bureau Chief

Maternal and child health services, as described in the Title V of the Social Security Act, are the responsibility of the Family and Community Health Bureau (FCHB). The Family and Community Health Bureau has a staff of 36 and a total budget of approximately $22 million. The FCHB manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children, family planning services, tribal programs and WIC. Approximately 91% of the total bureau budget is expended at the local level. The FCHB bureau is organized into four sections, which are:

- Maternal Child Health Coordination -- Ann Buss, Supervisor
- Children's Special Health Services -- Denise Brunett, Supervisor
- WIC/Nutrition -- Joan Bowsher, Supervisor
- Women's and Men's Health -- Colleen Lindsay, Supervisor

The Bureau also has an MCH Epidemiology Unit, led by Dianna Frick, and the Primary Care Office, led by John Schroeck.

An organizational chart of the Montana Department of Public Health and Human Services is available at http://www.dphhs.mt.gov/orgcharts/bureauorgchart.pdf. Organizational charts for the Public Health and Safety Division and the Family and Community Health Bureau are attached as a single document.

An attachment is included in this section.

D. Other MCH Capacity

The MCH BG supports 13.5 FTE at the state level in FFY 2010. Staff supported by the MCH BG are located in the MCHC and CSHS Sections, and in the MCH Epidemiology Unit. The Bureau Chief's salary is cost allocated to all programs and sections, based on the number of staff in the program. Other funding sources supporting staff in the FCHB include other federal funds (WIC, Title X, Newborn Hearing Screening and SSDI) and some general fund and state special revenues.

Key Title V staff in Montana include:

Jo Ann Walsh Dotson, RN, PhD -- Bureau Chief. Dr. Dotson has been the Bureau Chief of the FCHB since December of 1997. Dr. Dotson was an inpatient and outpatient pediatric nurse, and a faculty member in the College of Nursing at Montana State University prior to working for the state. Dr. Dotson's 2009 dissertation evaluated the home visiting program in Montana. Dr. Dotson is retiring from state government in the summer of 2010 -- the position will be recruited with a target start date of fall of 2010. On July 1, 2010 Joan Bowsher, WIC Director, was appointed as Acting Bureau Chief for the FCHB.

Ann Buss, MPA -- MCHC Supervisor. Ms. Buss has been the MCHC supervisor since 2006. She oversees seven staff responsible for general MCH service contract support, public health home visiting, oral health promotion, primary care recruitment and retention and bureau financial and administrative support. Ms. Buss completed her MPA in 2008 and the MCH Certificate program through RMPCH in 2009. She is a member of the Directors' Strategic Planning Committee, and

represents the division on the Interagency Coordinating Council for Women. Ms. Buss is also a member of the Legislative and Finance Committee of AMCHP.

Denise Brunett, BA -- CSHS Supervisor. Ms. Brunett has been the CSHS supervisor for two years. She oversees five staff and a contracted staff member responsible for the newborn screening and genetic programs, the regional clinics and CYSHCN referral services. Ms. Brunett represents the division on the HIPAA workgroup

Dianna Frick, MPH -- Lead MCH Epidemiologist Ms. Frick has led the Epidemiology Unit for two years. Ms. Frick has routine meetings with the medical officer who also serves as the state epidemiologist; a new position for a state epidemiologist was created and is presently being recruited to oversee a new Division level office of Epidemiology. One of the two MCH Epidemiologists, Dorota Carpenedo, is being moved to the new office once the lead position is filled. Ongoing coordination of the work of the MCH epidemiology unit with the new office will be needed over the coming years.

Montana CSHS has a CSH Committee that according to its charter, provides crucial input to the program regarding family concerns and needs. On this committee are three parents of children with special health care needs. At this time their involvement has been their attendance at committee meetings. The CSHS manager will continue to encourage as well as financially support their expanded participation for attending conferences and other appropriate training opportunities. (See attached CSHS committee charter in National Performance Measure 2)

In addition to program staff, administrative costs are allocated to all programs in the state agency to support fiscal, operations and legal services. Cost allocation is budgeted based on an analysis of services costs anticipated; cost allocation has increased annually for the last several years. In addition, administrative rule and MCH Service contracts allow county health departments to use up to 10% of the funds allocated to them for administrative purposes.

As stated earlier in this application, much of the capacity to address the health needs of the MCH population exists at the local level. Approximately 41% of the MCH BG received by Montana is distributed to counties through MCH contracts. In FY 2010, 54 of the 56 counties were funded and for FY 2011, an additional county indicated a desire to provide MCH services. Those amounts are based on an allocation formula that considers target population and poverty levels. The funding impacts the amount of time and subsequent work which may be "purchased" with the dollars -- some of the smallest counties receive only $1,500 per year. The funding does require that a designated individual be available to monitor MCH needs; the MCH BG helps support a portion of those positions, and in cases, provides the "anchor" or designated funding for public health in the county.

The Health Resources Division maintains a Family Health Line. Since January 2001, the Department of Public Health and Human Services' Family Health Line (1-877-KidsNow) has been the toll-free line on which Montanans can access information about health care programs for children and other health issues sponsored and promoted by the Department. Most of the calls received on the Family Health Line are related to HMK (the Children's Health Insurance Plan), but training has been provided to staff who answer the line to ensure that they are aware of programs to which families may be referred, including, but not limited to CSHS. See the attachment for the FCHB/MCH script.

An attachment is included in this section.

E. State Agency Coordination

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a manageable process. The fact that a few people wear

many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. People work diligently to meet local client needs as efficiently and effectively as scarce resources allow and many clients are served in common. Local input is regularly sought at the state level and is usually in the form of advisory councils, committees and/or functional work committees.

The Bureau structure facilitates excellent coordination between WIC, Family Planning and MCH Programs. The Bureau organizes and sponsors the Spring Public Health Conference, which provides an excellent opportunity for cross-training between local program staff. Bureau staff also work closely with staff in other bureaus, divisions and sections to address national and state performance measures. Examples of partnerships include coordination of programming to address childhood immunization rates with the immunization program, collaboration with the Health Resources Division on the Family Health Line, and referral of Medicaid and Children's Health Insurance Program (CHIP) families to CYSHCN as needed. Bureau staff participates on advisory groups such as the Montana Council for Developmental Disabilities and includes Family Voices representatives on the Children Special Health Services committee.

The Partnership Diagrams, included as an attachment for the Agency Capacity section, illustrate the Bureau's numerous collaborations with state and private human services agencies across Montana. These partnerships enhance as well as support the Bureau's programs addressing the health care needs of the MCH population, which are reflective of the priority health care needs and performance measures established for 2010.

F. Health Systems Capacity Indicators

Introduction

Montana continues to asses the indicators and data sources for the Health Systems Capacity Indicators (HSCIs) on an annual basis. The Health Systems Capacity Indicators most relevant to the state are used throughout the year to summarize aspects of maternal and child health. The State Systems Development Initiative (SSDI) makes a significant contribution to Montana's ability to report on and interpret data for the HSCIs by facilitating employment of a lead MCH Epidemiologist. The epidemiologist position is responsible for the annual assessment of data sources used for the block grant and exploration of new sources.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	23.1	24.9	19.8	18.8	18.8
Numerator	131	145	118	115	115
Denominator	56797	58191	59581	61114	61114
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008

2008 data are not yet available.

As of the 2008 submission, hospital discharge records are used to report the numerator for this indicator. 2005 is the first year that reflects this change in data sources. Prior to 2005 the numerator was Medicaid data. Reporting of hospital discharge records is not required in Montana. Not all facilities report discharge data and reporting may not be standardized. However, this source is the only statewide indication of hospitalizations for asthma among children under 5. The denominator is census estimates of children 0 through 4 years of age (May 2009 version).

Notes - 2007
As of the 2008 submission, hospital discharge records were used to report the numerator for this indicator. 2005 is the first year that reflects this change in data sources. Prior to 2005 the numerator was Medicaid data. Reporting of hospital discharge records is not required in Montana. Not all facilities report discharge data and reporting may not be standardized. However, this source is the only statewide indication of hospitalizations for asthma among children under 5. The denominator is census estimates of children 0 through 4 years of age (May 2009 version).

Narrative:
Medicaid claims data were used as the data source prior to 2005, although the records included only represent a subset of Montana's pediatric population. As of 2005, hospital discharge records are used as the data source for this indicator. Hospital discharge records that are available are currently considered a more complete source of data for this indicator than Medicaid. Although the quality of the limited hospital discharge data that are available continues to improve, a bill introduced in the 2009 legislature to require hospital reporting of discharge data did not pass.

Montana's Title V program does not have an asthma component, but the program does collaborate with projects related to asthma and healthy environments. Previously, Montana's Environmental Public Health Tracking (EPHT) Project is working with communities to identify the primary environmental health risks, some of which are possible risk factors for asthma. However, in 2006 the Environmental Public Health Tracking Project was not funded and the tracking activities have ceased. The 2007 Montana Legislature approved the use of general funds for asthma surveillance and control. As a result, the Chronic Disease Bureau of MT DPHHS recently initiated an asthma program and hired a coordinator. A report on the burden of asthma in Montana was released in 2007. A "Montana State Asthma Plan" was released in March 2009, developed by the Montana Asthma Advisory Group. The advisory group, formed in January 2008, includes over 30 individuals representing 25 agencies and organizations, including the Title V program, and works to coordinate asthma control efforts in the state. The plan describes strategies to improve surveillance systems, partnerships, and services for children with asthma. In particular, the plan calls for legislation to require hospital discharge data reporting.

The most recent National Survey of Children's Health (NSCH), with data from 2007, did not include a question about asthma-related hospitalizations as it did in 2003. It did measure prevalence, with 6.6% of Montana children 0-17 currently having asthma, as compared to 9.0% nationally. In addition, 3.3% of Montana children had asthma in the past but not at the time of the survey, compared to 4.5% of children in the U.S. While the NSCH data show that children in Montana have lower rates of asthma than the rest of the country, the actual prevalence of asthma in the state may be higher than reported. The survey question asked if a healthcare professional had diagnosed the child with asthma, so limited access to healthcare (an identified problem in the state) may influence the prevalence measure.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	88.3	91.9	88.0	92.7	88.6
Numerator	4635	1160	4717	5118	4883
Denominator	5249	1262	5359	5520	5510
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are for FFY 2009 from the EPSDT report from the Montana Medicaid Program.

Notes - 2008
This data for FFY 2008 came from the EPSDT report from the Montana Medicaid Program on 4/22/09.

Notes - 2007
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FFY 2007. cz

Narrative:
Montana's Medicaid program is in a different division of the MT Department of Public Health and Human Services than the state's Title V program. Collaboration does occur where appropriate around MCH-specific activities. For instance, the Children's Special Health Services (CSHS) section collaborated with Medicaid's PASSPORT program to promote the awareness of the medical home concept for CSHCN. Newborn screening also occur for the majority of Montana's newborns, regardless of whether they are Medicaid enrollees or not.

The denominator for 2006 was updated by Medicaid on March 9, 2009 resulting in change in the Annual Indicator from 22.7 to 91.9 for that year. 2006 data are considered to be an anomaly. In the most recent three years, the indicator shows an average of 90% of Medicaid enrollees receiving at least one screen.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.0	0.0	0	0	0
Numerator	0	0			
Denominator	1	1			
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data are not available for this indicator.

Notes - 2008
Data are not available for this indicator.

Notes - 2007
Data are not available for this indicator.

Narrative:
Montana's CHIP program does not collect data that can be used for this Health System Capacity Indicator. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids was implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level. Although this change may not affect Montana's ability to report on this capacity indicator, it is expected to increase the number of children who receive health care and screenings through the CHIP program.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	80.2	78.8	78.7	59.7	59.7
Numerator	9251	9818	9772	7498	7498
Denominator	11539	12462	12414	12567	12567
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
Data for this measure for 2008 should not be compared to prior years due to changes in the way the data are collected. The data source for this measure is the Montana Office of Vital Statistics. Both the numerator and the denominator reflect data on live births to Montana women 15-44 years of age, regardless of the place of occurrence. A new birth record format was implemented in 2008, following the 2003 revisions to the US Standard Certificate of Live Birth. The new birth record revised the way data on prenatal care initiation are reported. Also, due to the change the number of records with unknown or missing data increased. In 2008, the percent of births with unknown timing of prenatal care was 6.5%, compared to <1% in previous years. Among births with known prenatal care, 63.8% were less than or equal to 80% on the Kotelchuck Index.

Notes - 2007

The data source for this measure is the Montana Office of Vital Statistics. Both the numerator and the denominator reflect data on live births to Montana women 15-44 years of age, regardless of the place of occurrence. The 2007 data were updated for the July 2009 submission with final vital statistics data.

Narrative:
In 2008, Montana adopted the new birth certificate format (2003 revision of the U.S. Standard Certificate of Live Birth). 2008 data should not be compared with data from previous years due to the changes in the way the data are collected. The substantial decrease in early prenatal care initiation is believed to relate to the new birth record format and the change in the way the data are collected. Other states have experienced the same drop when the new format was implemented.

As the National Center for Health Statistics (NCHS) noted in Births: Final data for 2005, "Prenatal care data based on the revised certificate present a markedly less favorable picture of prenatal care utilization than those based on the unrevised certificate. For the first year the new certificates are implemented, the percentage of women reported to begin care in the first trimester typically falls in a state by at least 10 percent. Much, if not all of this decline is clearly related to changes in reporting and not to changes in prenatal care utilization. In brief, the revised item asks for the exact "date of the first prenatal visit," and the instructions recommend that the information be collected directly from the mother's prenatal care records. The 1989 Certificate, in contrast, includes the less specific "month of pregnancy prenatal care began" (e.g., 1st, 2nd, 3rd), and no source for these data is recommended. " From: Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. Births: Final data for 2005. National vital statistics reports; vol 56 no 6. Hyattsville, MD: National Center for Health Statistics. 2007.

Also, 6% of 2008 records have "unknown" timing of prenatal care initiation, a large increase from the approximately 2% reported in previous years. This is expected to improve in subsequent years as hospitals and staff become more familiar with the new birth certificate format. Among births with known prenatal care, 63.8% were less than or equal to 80% on the Kotelchuck Index. More complete data in subsequent years will indicate whether the unknowns resulted in an underestimate of the actual number of women with adequate prenatal care.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	88.7	86.1	97.5	93.4	91.0
Numerator	58602	51200	61532	58450	60207
Denominator	66078	59448	63136	62553	66147
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data source is the Montana Medicaid Program data, via QueryPath.
The data include for any children who were eligible for Medicaid during any part of the fiscal year and were less than 19 years of age. Providers have up to a year to submit claims. All claims for

FFY 2009 have not been processed and the actual percentage of recipients with a claim may be higher. 2009 data are provisional.

Notes - 2008
The data were updated for the July 2010 submission.
The numerator and denominator were obtained from Medicaid Program.
The data include any child that was eligible for Medicaid during any part of the fiscal year and was 18 or under at the start of the fiscal year.

Notes - 2007
The data were updated for the July 2010 submission. The numerator and denominator were obtained from Medicaid Program. The data include any child that was eligible for Medicaid during any part of the fiscal year and was 18 or under at the start of the fiscal year.

Narrative:
Montana's Maternal and Child Health program has limited influence over Medicaid-provided programs. Several MCH programs collaborate with Medicaid to try to increase care or educate Medicaid providers and program staff on possible services and interventions. For instance, the WIC and Children's Special Health Service (CSHS) programs both assist their clients to verify whether they are eligible and initiate enrollment in Medicaid where appropriate. CSHS, the MCHC section and the Oral Health Education Specialist have all developed relationships with Medicaid to collaborate on programs that will help serve children and facilitate their access to Medicaid services. Montana struggles with access to providers, particularly providers who will accept Medicaid, which certainly affects this indicator. As populations within the state shift towards larger population centers, rural areas are having more difficulty recruiting and keeping providers.

Transportation challenges and distances involved in getting to a health provider can deter families from using services. In some of the state's population centers, providers are over-booked and it may be a challenge to find a physician accepting new patients or Medicaid-eligible clients.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

The same data source was used for 2009 as for previous years. In 2006 there was a slight drop in the Medicaid-paid services, but the numbers increased in 2007. The indicator decreased again in 2008 and 2009, although 2009 data are not yet final, so the indicator may be an underestimate.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	34.3	33.4	39.7	52.2	38.6
Numerator	4182	4099	4897	6406	5112
Denominator	12182	12279	12320	12269	13231
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are from the EPSDT report from the Montana Medicaid Program for the FFY 2009.

Notes - 2008
This data are from the FFY 2008 EPSDT report from the Montana Medicaid Program.

Notes - 2007
This data are from the FFY 2007 EPSDT report from the Montana Medicaid Program.

Narrative:
Montana's maternal and child health (MCH) program has limited ability to affect Medicaid programs. However, the Oral Health Education Specialist (within the MCH program) continues to collaborate with Medicaid on dental access issues. Montana struggles with a shortage of dental professionals in the state. The shortage is even more severe in rural areas and when considering dentists who accept Medicaid and child clients. For children with behavioral problems or special needs, finding a dentist who will accept them as a client can be even more challenging. Montana continues to experience shortages in dental health professionals overall, and particularly in health professionals who serve Medicaid clients.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids was implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level.

The number of EPSDT-eligible children 6-9 years old who received dental services increased substantially in 2008, and then appeared to decrease in 2009. The increase in dental services in 2008 could be related to an increase in Medicaid dental provider rates that went into effect in October of 2007. Dental provider rates were increased from 64% of charges for children to 85% of charges in the aggregate. The reasons for the drop in 2009 are unknown. Montana continues to experience shortages of health professionals overall, and particularly health professionals who serve Medicaid clients.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.1	0.0	0.0	0.0	0.0
Numerator	22	0	0	0	0
Denominator	1957	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is					

fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
According to Montana State statute, children who receive SSI benefits automatically receive Medicaid benefits. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid.

Notes - 2008
According to Montana State statute, children who receive SSI benefits automatically receive Medicaid benefits. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid.

Notes - 2007
In 2007, 1929 children under 16 in Montana were receiving SSI payments. According to Montana state statute, children who receive SSI benefits automatically receive Medicaid. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid. According to the block grant guidance, the goal of this indicator is "for the state CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title SVI, to the extent medical assistance for such services is not provided by Medicaid." Due to the fact that Montana has met this goal, we have no data to report for this indicator.

Narrative:
During a review of the guidance for this indicator, and discussions with the Montana Children's Special Health Services Program, it was determined that no children meet the criteria to be reported in the numerator for HSCI 8. The guidance states the goal of this HSCI as "for the state CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title SVI, to the extent medical assistance for such services is not provided by Medicaid." In Montana, all children eligible for SSI are also eligible for Medicaid. From 2006 to 2009, no SSI beneficiaries under 16 in Montana received services through the CSHCN program that were not paid for by the Medicaid program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2009	payment source from birth certificate	8.6	6.7	7.4

Notes - 2011
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Narrative:

As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid. The overall rate of low birth weight in 2008 is 7.4%. The low birth weight rate among Medicaid-paid births is 8.6%. Among the non Medicaid-paid births, the rate is 6.7%. However, if the births with an unknown payer source are excluded from the non Medicaid group, the low birth weight rate drops to 6.3%. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2009	other	1	1	1

Notes - 2011

These data are not yet available. 2008 was the first year when payment source was available on the birth records. Linked birth-death-Medicaid fi;es have suggested that the rate of infant death among Medicai-paid births is significantly higher than among non-Medicaid births. However, due to the inability to verify some of the required information, the linked data files are not used as a source of this measure. Linked birth-death records that include delivery payment source may be available later in 2010, depending on the availability of vital statistics staff time to link the data sets.

Narrative:

A new birth certificate was implemented in 2008 that collects payment source for births. As of 2008, Montana collects primary source of payment as a part of the live birth record. In 2008, 30% of births were paid by Medicaid. Linked birth-death records using the new birth record format may be available in late 2010. Linked birth-death-Medicaid files have suggested the rate of infant death among Medicaid paid births is significantly higher than among non-Medicaid births. However, due to the inability to verify some of the required information, the linked data files are not used as a source for this measure.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving	2009	payment source from birth certificate	65.7	73.7	71.3

prenatal care beginning in the first trimester					

Notes - 2011
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Narrative:
As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid. Overall, 71.3% of women who gave birth in 2008 began prenatal care in the first trimester.

Among Medicaid-paid births, 65.7% of women started prenatal care in the first trimester. Among the non Medicaid-paid births, the rate is 73.7%. However, if the births with an unknown payer source are excluded from the non Medicaid group, the percent of women who started prenatal care in the first trimester increases to 78.9%. Among births with an unknown payer source, only 42.5% started prenatal care in the first trimester. However, timing of prenatal care initiation was unknown for 40.1% of the births with an unknown payor source. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	payment source from birth certificate	55.7	61.4	59.7

Notes - 2011
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Narrative:
As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. Overall, 6.5% of births had unknown adequacy of prenatal care. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid. Overall, 59.7% of women 15-44 years of age who gave birth in 2008 had adequate prenatal care. Among Medicaid-paid births, 55.7% of women had adequate prenatal care. Among the non Medicaid-paid births, 61.4% had adequate prenatal

care. However, if the births with an unknown payer source are excluded from the non Medicaid group, the percent of women with adequate prenatal care increases to 66.1%. Among births with an unknown payer source, only 32.7% reported adequate prenatal care and 38.1% had unknown prenatal care adequacy. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	250

Narrative:
These data come from the state Medicaid and SCHIP programs. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP (HMK/CHIP). During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. HMK/CHIP was implemented October 1, 2009 and the eligibility was expanded to 250% of the federal poverty level. Enrollment has been slower than expected, but the number of children enrolled continues to increase.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2009	 133 133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	 250

Narrative:
These data come from the state Medicaid and SCHIP programs. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and

coordinate coverage for uninsured children under Medicaid and SCHIP (HMK/CHIP). During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. HMK/CHIP was implemented October 1, 2009 and the eligibility was expanded to 250% of the federal poverty level. Enrollment has been slower than expected, but the number of children enrolled continues to increase.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2011
Montana's SCHIP (CHIP) does not cover pregnant women unless they are under 18 years of age (covered under CHIP as children).

Narrative:
These data come from the CHIP and Medicaid programs. In 2007, the Medicaid eligibility level for pregnant women was increased from 133% to 150% of the federal poverty level. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP (HMK/CHIP). HMK/CHIP was implemented October 1, 2009 and the eligibility was expanded to 250% of the federal poverty level. However, no provision for increased coverage of pregnant women was included in the bill or legislation. Enrollment has been slower than expected, but the number of children enrolled continues to increase.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

According to the latest Title V Information System (TVIS) data (reported by states in 2009), only 11 states had Medicaid eligibility levels for pregnant women lower than Montana's.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	1	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	Yes

Notes - 2011

Narrative:
The Family and Community Health Bureau (FCHB), Montana's Title V Program, does not have purview over the majority of the databases and surveys mentioned, with the exception of WIC, PRAMS, newborn screening, and the birth defects surveillance system. Therefore, while the Bureau is often involved in discussions regarding vital statistics data and linkages, it may not be the decision-maker.

Montana's Office of Vital Statistics links birth and death record files annually when the datasets are finalized and staff time are available.

Montana's new SPIRIT WIC data system was implemented in late 2009. The feasibility of the data storage and linkage are currently being investigated.

Montana's newborn screening system has been updated to accommodate the changes in the birth record format for 2008 births and allow for linking of records.

A bill introduced in the 2009 legislature to require hospital reporting of discharge data did not pass. However, several years with previous years of data are available with some limited use to the MCH program.

Montana has birth defects surveillance data through 2005. Active collection of birth defects data was suspended in 2005 when the newborn screening grant application to CDC was approved but unfunded. Discussions continue regarding possible future methods of collecting and using birth defects data. All of the data collected thus far are maintained by FCHB.

Montana received a PRAMS grant for a Point-in-Time survey in 2002. The funding application for a PRAMS grant in 2006 was not successful. The 2002 data are maintained by FCHB. At this time, FCHB is unable to conduct an independent PRAMS-like survey due to funding and staff

limitations. However, possible additional and alternative data sources continue to be explored.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
Montana's Office of Public Instruction (OPI) conducts and maintains the data from the Youth Risk Behavior Survey (YRBS). The YRBS has been conducted in Montana every other year since 1993, with the most recent results available for 2009. Montana's Title V program frequently uses YRBS data for grant applications and reports, and it is a valuable source of information for the five-year maternal and child health needs assessment.

As of 2008, the raw YRBS data are available to the MCH program. 2009 is the most recent year available.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Family and Community Health Bureau (FCHB) has served as Montana's Title V agency for over 20 years. In that capacity, the FCHB has continually monitored, assessed, provided, and advocated, to the extent possible, for the health and well being of the state's women of child bearing age, pregnant women, infants, children and children and youth with special health care needs. The Title V Maternal Child Health Block Grant provides a much needed funding source for addressing the MCH population's unique and oftentimes challenging health needs. In spite of the challenges, an average of 97,007 women, infants, children and children with special health care needs received services supported by the MCH Block Grant.

Montana's 2010 MCH Needs Assessment is a compilation of information, reflecting the work of FCHB programs, and public and private partner organizations. The 2010 MCH Needs Assessment also included input from consumers, which included teens, parents of children with special health care needs, and parents of children and infants ages 0 to 12 years; Montana's Lead Local Public Health Officials; health care professionals; members of the Public Health System Improvement (PHSI) Task Force; and representatives from county health departments that are contracted to provide MCH services in their communities.

There was a consensus from the PHSI Task Force and others working on the SPM selection that Montana must focus on improving Montana's childhood immunization rate; Montana presently has the worst IZ rate for the 19-35 age group in the country. Because of the magnitude of concern, two SPMs were selected to complement the existing NPM 7. SPM #6 focuses on children 19-35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis and SPM #7 specifically addresses compliance with the state's requirement of a Varicella immunization for children 19 to 35 months of age. The other five state performance measures address access to care; oral health for children; preconception health; child safety and unintentional injury; and smoking during pregnancy.

Through the years, the FCHB has increased its partnerships and collaborations with other state agencies and private entities for the purposes of providing program activities aimed at any one of the four service levels found in the MCH Pyramid: direct health care, enabling, population-based, and infrastructure building. The new SPMs offer numerous opportunities for developing new partnerships, as well as strengthening the current partnerships, with the goal of maximizing and leveraging when possible, state and federal dollars for the purposes of improving the health of all Montanans, especially the MCH target population.

B. State Priorities

The Family and Community Health Bureau (FCHB) solicited input on the needs of the MCH population, resources and gaps, and capacity through surveys of local partners and programs providing MCH-related services, focus groups, and key informant interviews. In the fall of 2009, 34 topics were initially identified as possible priority areas for the MCH population. These topic areas included exposure to secondhand smoke in childhood, adolescent tobacco, alcohol and drug use, women's mental health and safe home environment. A more detailed list of the thirty four suggested priority areas is included in the 2010 MCH Needs Assessment document.

Subsequent meetings of the FCHB Needs Assessment Planning Team produced a more reasonable list of priority areas. The initial methodology for selecting the priority areas included:

- Relevant to one of the three MCH populations
- Stakeholder/public input indicates an interest or need
- Data available on the topic

- Data supports need
- Capacity to address topic
- Political will/interests
- Not already measured by a National Performance Measure
- Within the responsibility of the MCH or CYSHCN Director
- System in place to address the need
- Topic or issue can be sufficiently focused
- Possible interventions or approaches to address priority area can be identified

After the FCHB Needs Assessment Planning Team narrowed down the list using the criteria, discussions took place with the Public Health System Improvement (PHSI) Task Force. The PHSI Task Force includes representatives from local health departments (one each from large, medium, small, and frontier-sized counties), and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service.

The stated purpose of the PHSI Task Force is to:
- Assess Montana's progress in implementing the goals and objectives of the Strategic Plan for Public Health System Improvement and other system improvement efforts.
- Ensure the implementation of the Strategic Plan with updated "action plans."
- Provide policy development recommendations to state and local agencies regarding public health system improvement issues.
- Advocate for statewide public health system improvement efforts.

Source: (PHSITF Charter retrieved 6/7/2010 at http://www.dphhs.mt.gov/PHSD/phsi/pdf/2009-PHSI-TaskForceCharter.pdf)

The PHSI Task Force was responsible for the final identification of the MCH priority areas and state performance measures based on the availability of data on a measure to indicate a baseline or progress toward a goal, the political and financial support/resources to address the priority area, and most importantly, the capacity for addressing the priority area at a state or local level. Furthermore, the PHSI Task Force recommended that the MCH priority areas and new state performance measures have an identified measure that was relevant at either the state or local level.

The following are Montana's priority areas for its MCH population for 2010 - 2015:
- Child safety/unintentional injury
- Access to care
- Preconception health
- Smoking during pregnancy
- Oral Health
- Montana's rate for the required Varicella immunization
- Montana's rate for the required Diphtheria, Tetanus, and Pertussis immunization series

The FCHB is one of five bureaus in the Public Health and Safety Division (PHSD), which has created its own 2007-2012 Strategic Plan to addresses its mission: To improve the health of Montanans to the highest possible level. The PHSD Strategic Plan (attached document) includes several Health Improvement Priorities that target the MCH population and can be tied to a national performance measure (NPM) or state performance measure (SPM), as illustrated:

PHSD Strategic Plan Health Improvement Priority Area and Related NPM and SPMs

Maintain programs that provide services to women (pre-pregnancy, prenatal, and post-natal) and children.
NPM #1, #2, #3, #4, #5, #6, #8, #9, #11, #12, #13, #14, #17, #18
SPM #1, SPM #2, SPM #3

Reduce unintentional injuries and deaths among Montanans from motor vehicle accidents, falls, poisoning, and other preventable injury-related deaths.
NPM #10, NPM #16
SPM #4

Increase the number of tobacco-free Montanans.
NPM #15
SPM #5

Increase childhood immunization rates for Diphtheria, Tetanus, Pertussis, Varicella and other vaccine
preventable conditions.
NPM #7
SPM #6, SPM #7

The selection of state needs and priority areas is an ongoing process requiring assessment of health
status and system functioning indicators as well as the availability of financial and human resources. The fiscal impact of MCH Block Grant funding remaining at the same level for the past several years has been felt in Montana. As mentioned elsewhere in this application, approximately 42% of the state's MCH Block Grant allocation is distributed to 54 of the state's 56 local health departments. Lack of an increase in the MCH Block Grant does not provide for the ongoing increase in the cost of providing services at the local level. Thus, Montana's total number served continues to decrease.

Fiscal and human resource challenges affect every state, but are perhaps more distinct or apparent where the rural/frontier nature and sparse distribution of clients and providers place multiple demands upon a very fragile public health infrastructure. As the FCHB moves forward with the new priority areas and state performance measures, the FCHB 2010-2015 MCH Block Grant Strategic Plan is the tool that will be used to monitor, assess, and evaluate that the State Title V Agency and the FCHB continue to have the capacity and resource capability for addressing the national and state performance measures.

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	2	7	9	17	15
Denominator	2	7	9	17	15
Data Source				MT newborn screening and follow-up program	MT newborn screening and follow-up program
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Fewer cases were confirmed and received timely follow-up compared to the previous year based on the mandatory hospital-based screening of newborns for 28 genetic conditions.

Notes - 2008
2008 was the first year Montana had mandatory hospital-based screening of newborns for 28 genetic conditions. This performance measures includes the results and follow-up for those tests. The increase in the number of conditions is due to the increase in the number and types of tests conducted.

a. Last Year's Accomplishments
The Montana Newborn Metabolic Screening Program (MNMSP) is a partnership between Children's Special Health Services (CSHS), the Montana Public Health Laboratory (MT-PHL), and the baby's provider. The overall goal of the Montana Newborn Metabolic Screening Program is that every newborn with an initial positive or screen positive result is tracked by the program coordinator to a normal result or appropriate clinical care.

The MT-PHL received all Montana bloodspot specimens and screened for phenylketonuria, galactosemia, congenital hypothyroidism, hemoglobinopathies, and cystic fibrosis. Specimens were then shipped to the Wisconsin State Laboratory of Hygiene (WSLH) for completion of the screening panel. More than 5% of babies needed a program-mandated repeat screen due to unsatisfactory specimens or out of range test results on the initial newborn screen. The newborn screening (NBS) coordinator was responsible for short term follow-up to ensure that repeat screening occurred, and facilitated secure information sharing of positive screening results with the long term follow-up contractor. The coordinator manually matched screening records to birth certificates and identified babies who needed screening within weeks of birth. Matching revealed a 1% loss of newborn screening specimens during transport to the MT-PHL. Providers were promptly contacted to arrange for collection.

A very high percentage of Montana's newborns (99.2%) received at least one bloodspot screen in 2009 that included the American College of Medical Genetics recommended panel. Of the 12118 infants (12078 with a Montana birth certificate) who received at least one Montana newborn screen in 2008, 26 were screen positive for one of the 28 mandated conditions. Of these, 15 were diagnosed with a condition and are being treated. An additional 19 infants were presumed carriers of abnormal hemoglobin traits and referred for follow-up genetic services. Babies with diagnosed conditions in 2009 included five with congenital hypothyroidism, one with a galactosemia variant, two with a disorder of fatty acid metabolism, four with organic acidemia, and three with cystic fibrosis.
The MNMSP continued to consolidate, evaluate and improve the systems put in place in January 2008 with expansion of the newborn screening panel. The coordinator attended the Association of Public Health Laboratories (APHL) Newborn Screening Symposium in November 2008, and participated in the Mountain States Genetics Regional Collaborative Center (MSGRCC) newborn screening workgroup. The coordinator helped present a program update to a state-wide clinical laboratory meeting in April 2009. Feedback from parents and providers guided revision of a new parents' brochure listing screened conditions. CSHS updated the program website (http://newborn.hhs.mt.gov) in May 2009 to include information about both newborn metabolic

and hearing screening.

In June 2009, the NBS coordinator position was re-defined under the supervision of the MT-PHL. The coordinator had more direct access to laboratory data to carry-out short term follow-up. The coordinator prepared a draft "Lost to follow-up protocol" in August 2009 for babies with initial invalid or out of range results.

MNMSP partners (CSHS, laboratory, follow-up contractor) met monthly and reviewed program statistics (% babies screened, initial positives, screen positives, confirmed diagnosis, treatment), accomplishments, and challenges for calendar year 2009 in order to improve sustainability and accountability for the program. Procedural issues were addressed regarding formation of a Montana NBS Work Group. The clinical long term follow-up contract (with the Montana Medical Genetics Program at Shodair Children's Hospital in Helena) was extended beyond December 31, 2009 after a formal assessment by CSHS of contractor compliance. Contractor responsibilities were clarified to help the program meet the needs of infants, children, and families diagnosed with screened conditions, and help the program provide more direct specialist support to Montana's primary health care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn metabolic screening data with Montana birth certificates				X
2. Identify babies with Montana birth certificates who have no newborn screening data within two months of their birth and determine reason for no screening		X		
3. Ensure that all newborns with confirmed conditions are referred to the contractor for long-term follow-up and consultation with the primary care provider in the medical home.		X		
4. Ensure partners and decision makers review program statistics, accomplishments, and challenges to improve sustainability and accountability for the program.				X
5. Apply standards consistent with Wisconsin’s for specimen acceptability; continue submitter education about satisfactory specimens; monitor and maintain unsatisfactory rate at less than 2%.		X		
6. Expand program web site to include more provider information.				X
7. Develop specimen transport log sheet to ensure timely delivery of NBS specimens to MT-PHL.				X
8.				
9.				
10.				

b. Current Activities

The coordinator prepared an "Unsatisfactory Specimen" policy in December 2009 for the MT-PHL. Standards consistent with WSLH are now applied to Montana specimens. In December 2009 the MT-PHL called more than 7% unsatisfactory. The coordinator provided submitters with intensive education and reinforcement by phone and email. Unsatisfactory specimens dropped to 1.3% by April 2010 and continue at this level.

The coordinator and the NBS laboratory supervisor continue to work toward more concise screening reports, with clearly identified abnormal results and appropriate recommendations,

which are readily available to the newborn's medical home. The NBS laboratory supervisor and the contractor's care coordinator attended the APHL Newborn Screening and Genetic Testing Symposium in May 2010.

The MNMSP partners (CSHS, MT-PHL, and follow-up contractor) continue to meet regularly and cooperate in educational endeavors. This group reached consensus on a change in reporting protocol for unknown hemoglobin variant traits which was then adopted by the MT-PHL.

c. Plan for the Coming Year

The Advisory Committee on Heritable Disorders in Newborns and Children added screening for Severe Combined Immunodeficiency (SCID) to the recommended panel in May 2010. Montana will evaluate developments in SCID screening nationally in the upcoming year.

Second tier tests (performed on the same bloodspot specimen after initial out of range results) are now available for many conditions at higher volume screening laboratories. These tests may increase the positive predictive value of the screen and reduce the number of infants who need repeat screening or diagnostic testing. The MT-PHL plans to submit de-identified specimens to a regional CDC-funded project evaluating 2nd tier testing for congenital adrenal hyperplasia and other conditions. A biochemical geneticist at the University of Utah and ARUP Laboratories is the principal investigator.

Previously, a biochemical geneticist from Colorado traveled to Montana to staff regional metabolic clinics and was available remotely to advise the follow-up contractor. Starting June 2010, a board-certified biochemical geneticist will be employed directly by the follow-up contractor. He plans to maintain a residence in Montana and will have more direct involvement with the MNMSP partners and with primary providers.

The program web site will be expanded to include more information for providers and families.

The NBS coordinator will take part in a quality improvement project to evaluate specimen transport processes and develop a specimen log sheet for submitters to track specimen transport times to ensure timely delivery of specimens to MT-PHL.

The partners (CSHS, MT-PHL, and follow-up contractor) will continue to meet regularly and cooperate in educational endeavors.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**12204**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%

Phenylketonuria (Classical)	12078	99.0	2	0	0	
Congenital Hypothyroidism (Classical)	12078	99.0	7	5	5	100.0
Galactosemia (Classical)	12078	99.0	3	1	1	100.0
Sickle Cell Disease	12078	99.0	0	0	0	
Congenital Adrenal Hyperplasia	12078	99.0	2	0	0	
Cystic Fibrosis	12078	99.0	5	3	3	100.0
Homocystinuria	12078	99.0	1	0	0	
Maple Syrup Urine Disease	12078	99.0	0	0	0	
Fatty Acid Oxidation Disorders	12078	99.0	2	2	2	100.0
Tyrosinemia Type I	12078	99.0	0	0	0	
Hemoglobinopathy	12078	99.0	19	0	0	
Organic aciduria disorders	12078	99.0	4	4	4	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	55.3	55.6	56.5	56.5
Annual Indicator	54.0	54.0	56.5	56.5	56.5
Numerator	188	188			
Denominator	348	348			
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	56.5	56.5	56.5	56.5	56.5

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The client satisfaction survey process was repeated at the regional pediatric specialty clinic (RPSC) for Cystic Fibrosis (CF) Clinic clients, during April-July 2009. Health coverage questions were added to the survey. Seventy-eight percent of clinic attendees and family members reported that CF clinic was great in terms of feeling listened to by health care professionals, health care professionals providing information, answering questions and being friendly and helpful with an overall clinic experience rating of "great!" Twenty-two percent of CF clinic attendees reported these same criteria as "good." Ninety-two percent of these clients had attended CF clinic more than 3 times. The majority reported that the number of times clinic is held is "just right."

The Children's Special Health Services Committee workgroup evaluated ways to assist families with transportation costs to specialty clinics and recommended follow up services. These activities were suspended due to lack of resources.

CSHS continued to promote parent participation by sponsoring attendance at condition specific workshops and through expanded parental participation on the CSHS committee. A parent representative attended the 2009 Early Hearing Detection and Intervention (EHDI) conference in Dallas and recommended that all agencies need to work together to build a system of care for infants and children identified with hearing loss. A parent representative attended the June, 2009 CSHS Committee meeting.

Parents continued to determine how they want to spend their CSHS financial support for their child's diagnosis and treatment plan. CSHS staff maintained personal communication with children and youth with special health care needs children and youth with special health care needs (CYSHCN) parents and discussed with them how best to maximize the CSHS stipend earmarked for their child's uncovered medical services.

CSHS staff maintained close communication with the families as children were enrolled or re-enrolled in the program. Staff reviewed with the families, the total allocation for the FFY and discussed what services were needed, what insurance coverage was available (to enable CSHS funds to go further). Staff worked with parents to explore the needed services which might be available through other programs (school district, Head Start, etc), or if a provider may have financial assistance available.

CSHS participated on the Part C Advisory committee which consisted of parents, providers, partners and state agency representatives.

The RPSC exit interview process continued with the Nurse Coordinator visiting each family to ensure that their questions were answered and to confirm that they understood the next treatment steps.

Children's Special Health Services (CSHS) continued to have regular contact with Dr. Laura Nicholson, who provided clinical guidance and chaired the CSHS Committee. The committee membership met twice a year and has the following roles and responsibilities: 1) Provide information from providers, service users, and others to promote short and long range planning to meet the health care needs of children and youth with special health care needs (CYSHCN) as defined by the Program; 2) Review and advise regarding policy decisions indicated as a result of changes in federal statutes, federal requirements and regulations, state plan amendments,

administrative rules, and state legislative actions; 3) Monitor, review, and evaluate the allocation of resources and access to health care services for children served by the program; 4) Identify service gaps and unmet health care needs of CYSHCN statewide and make recommendations to the Department; and 5) Review and provide input on health care initiatives and proposals regarding CYSHCN.

The CSHS Advisory Committee underwent changes to expand community representation. The committee invited a community representative from the Montana School for the Deaf and Blind (MSDB) to participate on the CSHS Committee. The invitation was accepted and the MSDB representative has been a great addition.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued active parent participation in CSHS Advisory Subcommittee to the Family Health Advisory Council.				X
2. Review comments from exit interviews for program modifications at the Regional Pediatric Specialty clinics.				X
3. Ongoing collection and analysis of the client satisfaction survey from the Regional Pediatric Specialty clinics.				X
4. Parent participation and input on the CSHS activity plan.				X
5. Partnership building with Parents Let's Unite for Kids (PLUK), MSDB, parents and CSHS.				X
6. CSHS Medical Director to continue to provide technical assistance and guidance.				X
7. CSHS implemented rotational (quarterly) CF interdisciplinary clinics in all 3 regions.			X	
8.				
9.				
10.				

b. Current Activities
Shodair, the contractor for the genetics and newborn screening programs, conducted patient satisfaction surveys. See attachment pages 11-12.

Shodair is conducting its 2nd annual Metabolic Day in August of 2010. The event will host families, provide information about metabolic conditions and the impact on the child and family as well as offer support and networking.

Shodair created binders for the metabolic patients attending inter-disciplinary clinics. The binders have gender specific materials and are to hold all clinic related materials so the patient and family can retain and organize condition and gender specific information.

CSHS staff also began assessing the need for additional support for families purchasing coverage for CYSHCN.

CSHS added a .5 FTE professional nurse to each region in an effort to reduce the nurse-patient ratio of 1:850+ and therefore ensure better care and service for children and their families.

CSHS listed several activities that could be done with additional resources. Some ideas were to create a parent resource library, use social media to offer parent-to-parent contact, and to create an ongoing means to solicit parent feedback about accessing services in Montana. These activities were limited due to lack of staffing and resources.

The CSHS Committee welcomed a new parent representative. This person has actively been involved in reviewing and sharing feedback on program materials. She attended her first committee meeting in June of 2010.

c. Plan for the Coming Year

The CSHS data coordinator will contact participating hospitals and clinics to evaluate the types of client satisfaction surveys they use and the information they collect in order to assess its relevance to CSHS. Once this has been done, the CSHS data coordinator, in collaboration with the CSHS program and a MCH epidemiologist, will evaluate CSHS data needs. Then either a survey will be developed for CSHCN clients and parents regarding partnering in decision making and the ability to make decisions about the services they receive, or CHSH will collaborate with the hospitals and clinics to develop one survey tool that will collect both the data they require as well as the information CSHS needs. This will prevent duplication of data that is collected from patients and families.

There will be a follow-up assessment on the Newborn Screening Follow-up Program and Metabolic Clinic. The initial assessment was completed in February 2010. There were three areas assessed and scored: contract service performance (rating was marginal), cost control (rating was satisfactory) and staff and business practices (rating was satisfactory). A follow-up assessment will be completed by February 2011.

Effective June of 2010, a metabolic geneticist has been contracted for the newborn screening follow-up services and will be onsite at Shodair, It is anticipated that the presence of a metabolic geneticist in state will allow for clinic expansion, improved access and newborn screening program development.

Shodair will continue as the contractor for the genetics program in MT and at each genetics clinic, will survey each family about the clinic interaction and if their feelings are valued and respected.

CSHS will continue to monitor patient satisfaction surveys performed by Shodair.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60.2	52.6	52.6	50	50
Annual Indicator	51.7	51.7	45.9	45.9	45.9
Numerator	361	361			
Denominator	698	698			
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
Continued work to web enable the Child Health Referral & Information System (CHRIS), the CSHS database, began in November 2008. Work to include functionality continued to allow a child's primary care provider (PCP) to view clinic schedules with specialty provider information, to make electronic client referrals for clinic evaluations, and to access newborn screening information for their clients. The target date for completion is 2011. The electronic capability will provide PCPs with current information about available services statewide and do much to facilitate care for newborns and CYSHCN.

The initial design and infrastructure of the web application has been completed. The module for tracking hearing and vision services by the MT School for the Deaf and Blind (MSDB) is being tested in anticipation of rollout by the start of school fall 2010. Master Newborn functionality which links hearing and metabolic records with birth certificate data is complete. Clients needing follow-up for hearing loss or metabolic conditions can now be referred to the client management module of the CHRIS application. The provider portal to allow primary care providers access to care plans for children attending interdisciplinary clinics will be developed during the 2011 funding cycle.

CSHS worked to explore a medical home definition and continued to work with the CSHS medical advisor.

In partnership with Medicaid, an application was submitted to the National Academy for State Health Policy (NASHP) for one year of technical assistance (TA) for up to eight states seeking to improve the availability of medical homes in their Medicaid and Children's Health Insurance Programs. CSHS partnered with Medicaid staff and submitted an application.

CSHS continued to participate in the MT Academy of Pediatrics (MAAP) to address topics such as reimbursement rates, medical homes & transportation issues.

Pediatric specialists provided in-services for pediatricians, family practice physicians, and other providers at the Regional Pediatric Specialty Clinics. Specialists included: Anthony Bouldin, MD, Pediatric Neurology (Seattle); Peggy Schlesinger, MD, Pediatric Rheumatology; Jerald Eichner, MD, Pediatric Pulmonology; Jeff Wagner, MD, Pediatric Pulmonology (Denver); Michael Narkowitz, MD, Pediatric Gastroenterology (Denver); Michael Kappy, MD, Pediatric Endocrinology (Denver); Susan Apkon, MD, Pediatric Physiatrist (Denver); Marilyn Manco-Johnson, MD, Pediatric Hematologist (Denver); Ruth McDonald, MD, Pediatric Nephrology (Seattle). These regional educational meetings offered learning opportunities as well as facilitating communication between the medical home and specialty providers. Medical students, nursing students, hospital staff & others also attended these presentations.

Clinic coordinators continued to be directly responsible for ensuring that each child seen in the Regional Pediatric Specialty Clinic (RPSC) has a PCP and that all treatment recommendations

from specialty clinics are communicated to the PCP for coordination & continuity of care.

Follow the Child (FTC) uses PH home visiting to promote health outcomes for children living in foster care by providing training to foster parents, compiling medical records of foster children, and facilitating medical and mental health coordination of care. Prior to the 2009 legislative session a presentation was made to DPHHS Family Services Division. They were supportive of the project but no funding was identified. The Missoula legislative group submitted a legislative request for funding to support and to extend FTC to other counties. This was not successful. However, Missoula , Glacier , and Cascade counties are home visiting foster care.

The contractor for the newborn screening follow-up program, Shodair, reported 60 patients were invited to metabolic clinics. 58 patients (97%) have a verified primary care provider medical home and 46 (77%) attended the clinics. The multidisciplinary metabolic clinics served as a partial medical home with coordinated, ongoing, comprehensive medical care.

During April-July 2009, clients at Cystic Fibrosis (CF) Clinic were asked about having a PCP. All but one of the clients in the survey reported having a PCP; 34% reported seeing their PCP within the past month, 39% reported seeing their PCP within the past 6 months, 24% reported seeing their PCP within the past year and the remainder had not see their PCP within the past year.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All regional pediatric specialty clinic participants are tracked and referred to medical home as needed.			X	
2. Continue to support and update the CSHS website, which includes medical home links.				X
3. CSHS also plans to continue to strengthen the relationships between the pediatric specialty clinics and primary care providers.				X
4. CSHS to continue development of the provider portal which will allow primary care providers to access care plans for children attending interdisciplinary clinics will developed during the 2011 funding cycle.				X
5. CSHS to continue participating in the Medical Home Stakeholder Workgroup.				X
6. Regional staff to continue facilitating in-services and education opportunities.				X
7.				
8.				
9.				
10.				

b. Current Activities
CSHS continued participation in the NASHP TA grant. There have been 2 stakeholder meetings where participation included Children's Mental Health Bureau, hospital administrators, providers, health insurance company medical directors, county health representatives & two MT Legislators. The stakeholder group has received expert advice regarding establishing a multi-payer medical home concept for the entire state, how to fund such an effort, and assistance to facilitate these discussions.
Dr. Nicholson continues to serve as a CSHS advocate and conducts outreach to providers regarding coordinating services & specialty shortages in MT.
CSHS is negotiating with 2 of the 3 regional clinics to add a case-manager to the pediatric

specialty clinics. The goal is to improve communication with the medical home and assess needs of the family in order to streamline follow-up and coordinate care for CYSHCN.
At the time of diagnosis, Shodair works with families to identify a primary care medical home for all patients. If patients relocate to other communities, Shodair assists in contacting a primary care provider. Shodair provides comprehensive medical follow-up services for individuals with conditions identified via newborn screening.
Shodair reported 58 patients verified they had a primary care provider; 46 of these patients attended a metabolic clinic in FFY 2010. This translates to 77% of the patients attending clinics reported having a medical home.

c. Plan for the Coming Year
CSHS will continue to participate in Medical Home Stakeholder meetings. In the coming year, the stakeholder group will adopt criteria to certify practices as Medical Homes and possible include a self-assessment tool. Also, CSHS will continue to be involved in planning a medical home initiative to include a certification process for practices that choose to participate. MT Medicaid will also be assessing and proposing a revamped PMPM (per member/ per month) payment system, and a pay for performance component.
CSHS staff coordinated the MT Academy of Pediatrics speaker at the fall conference. The guest speaker will be Dr. Peter Von Dorsten, who is the one provider of cochlear implants for children in MT.
CSHS is contracting with a nurse to assess the different CYSHCN referral sources. Ideally, the contracted nurse will develop a referral program that will coordinate the referrals of the CYSHCN to county health departments to ensure each referral receives services.
CSHS is now in the 3rd year of web development of the CHRIS application. Scheduled for completion during this SFY 2011 is a web portal, which will allow PCP and specialty providers with appropriate security to access and update their client's care plans, thus facilitating a comprehensive medical home approach.
CSHS will draft cystic fibrosis care plans which can be accessed by regional nurse coordinators in an effort to communicate with medical homes and CYSHCN and their families.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.5	50.4	50.5	55.2	55.2
Annual Indicator	48.8	48.8	55.2	55.2	55.2
Numerator	350	350			
Denominator	717	717			
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55.2	55.2	57	58.5	58.5

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The Regional Pediatric Specialty Clinics (RPSC) and Children's Special Health Services (CSHS) continued to educate families about their health coverage options such as Healthy Montana Kids (HMK/CHIP), Health Montana Kids Plus (HMKP/Medicaid), and private health care coverage.

The regional coordinators received continuing education regarding health care coverage, including documentation for Social Security Disability Income (SSDI) application, for this population.

The spring survey of cystic fibrosis (CF) clients reported that all clients had at least one health payer source. Seventy- eight percent had private health insurance as their primary payer source; 21% of these clients had a 2nd private health insurance; and 33% had Medicaid as a secondary payer. Twenty-four percent had Medicaid as their primary payer source and 30% of clinic attendees are receiving Social Security Disability.

CSHS continued partnering with the HMK and HMKP to increase access for needed benefits for children and youth with special health care needs (CYSHCN).
CSHS facilitated discussions between HMK, audiologists and the Montana School for the Deaf and Blind (MSDB) regarding hearing aid options, determining fee schedules and replacement insurance coverage. As of October 1, 2008, hearing aides are a HMK benefit and CSHS began covering the cost for the hearing aid warranty and batteries as HMKP is not able to cover these supplies.

CSHS continued to partner with the Disability Determination Bureau to provide SSI applicants with information about the availability of other programs that may provide them with assistance. These families contact CSHS for a variety of issues, including where they can access assistance with education services, payment for services not covered by Medicaid, where they may obtain additional evaluations which may qualify their child for SSI, and transportation concerns.

During FFY 2009, 71% of active CSHS clients had a source of payment for health care including private insurance, 42%; Medicaid 28%; Indian Health Services (IHS) 1%; and health coverage status was unknown for 29%.

Since October 1, 2005 CSHS has billed Montana Medicaid, CHIP, and about 20 private health insurance plans for clients who attended cleft/craniofacial and metabolic clinic.
As of September 30, 2009: $882,100 was billed: $544,443 was paid; $337,657 was not paid for cleft/craniofacial interdisciplinary clinics; $212,299 was billed; $103,940 was paid; $108,358 was not paid for metabolic interdisciplinary clinics. Approximately $1,094,399 was billed; $648,384.was paid; $446,015 was not paid; resulting in other sources paying the balance or the balance is forgiven. CSHS continues to address the outstanding balance as this revenue allows families to receive medical care in-state.

In FFY 2009 CSHS received 79 financial assistance applications. Sixty-one clients were eligible for up to $2,000 in health care coverage assistance. Of this, 1 was self-pay; 12 were HMK; 14 were HMKP; and the remaining 52 had some type of health coverage as a primary payer. A total of 77 children/families received an average of $807.49 for medical care and prescription services. ***An attachment is included in this section.***

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued limited financial assistance for medical services	X			
2. Continued partnership with Medicaid program regarding specialty services in Montana.		X		
3. Ongoing shared referrals with CHIP.		X		
4. Communication with providers to accept negotiated rate.		X		
5. Provide information to CHIP, Medicaid and other insurance regarding coverage needs of CYSHCN.				X
6. Provide information to health care providers regarding the Healthy Montana Kids expansion.		X		
7. Health coverage assessment of CF clients related to clinic expansion.				X
8. Continue payment negotiations with health care payers for CSHS interdisciplinary clinics.		X		
9.				
10.				

b. Current Activities

RPSC and CSHS continue to educate families about their health coverage options such as HMK, HMKP, and private insurance.

In December of 2009, CSHS implemented CF inter-disciplinary clinics. This clinic will be held on a rotational basis so there is a clinic each month in MT.

Since October 1, 2005 CSHS has billed multiple payers for the inter-disciplinary clinics. Refer to the attachment for payer and payment detail.
CSHS planned to provide more ongoing education to RPSC staff about private insurance options, prior authorization, waiting periods, & pre-existing exclusions, but were unable to accomplish this due to staff resources being utilized elsewhere.

Effective February 2010, CSHS began receiving SSDI summaries of findings. The physician-drafted forms assess the status of a child's disability.

For FFY 2010, to date, 45 clients were eligible for up to $2,000 in health care coverage assistance from CSHS. Of the 45, 1 did not have health care coverage; 16 had HMK; 6 had HMKP; and the remaining clients enrolled had some type of health coverage. CSHS enrollment continues to decline due to the changes made in HMK & HMKP. Both programs have raised their poverty guidelines for eligibility.

In December 2009 a 2% rate increase was implemented for targeted case management (TCM) programs for high risk pregnant women & CYSHCN.

CSHS continues to work with Indian Health Services prior to conducting reservation specialty clinics to ensure that families have a health payer source.

c. Plan for the Coming Year
CSHS, regional clinic staff and Shodair will continue to assess health care coverage at regional pediatric specialty clinics. CSHS staff will continue to work with non-profit agencies and patient assistance programs that help the under-insured. Also, CSHS will continue supporting the three inter-disciplinary clinics (cleft/craniofacial, metabolic and cystic fibrosis). CSHS plans to continue providing pediatric specialty clinic services without charging families any team clinic expense.

CSHS began billing for CF clinic December 1, 2009. CSHS has received approval to bill HMK, HMKP, New West Health Services, Allegiance, and Timber Products for CF interdisciplinary pediatric services provided. CSHS will continue coverage negotiations with Blue Cross Blue Shield (BCBS) of Montana and Employee Benefits Management System (EBMS) regarding payment for CF interdisciplinary pediatric clinic services provided.

Since October 1, 2005, and continuing to do so, CSHS will strive to decrease the number of claims that are either denied or partially paid by negotiating with payers. CSHS plans to obtain more revenue to provide more interdisciplinary pediatric services to Montana's children with special health care needs.

CSHS will continue monitoring the cost of the three inter-disciplinary clinics. If resources allow, CSHS will begin evaluating the ability to add physician and regional staff requested for other inter-disciplinary clinics such as orthopedic, neuromuscular, NICU follow-up or juvenile arthritis.

Cleft/Craniofacial clinics have provided the services of a multidisciplinary team for children with clefts and their families in Montana for approximately 60 years. Montana has enjoyed the commitment of numerous professionals over the years, many of whom volunteer their time and expertise to see families in clinics at Missoula, Great Falls, Billings, Wolf Point, Browning, Helena, Kalispell and Bozeman. CSHS proposed presenting certificates (for less than 10 years) or plaques (for 10 or more years) to 91 providers at in-state professional association meetings or conferences. The Department director will be invited to present these awards. Some of the meetings and conferences identified are the MT Medical Association, the MT American Academy of Pediatrics, and the National Association of Social Workers. Additionally, CSHS will work with the DPHHS Public Information Officer to develop press releases and other media opportunities to recognize the work of the teams. It is anticipated this process will take over a year as the conferences tend to be held once a year, in the spring or fall.
The Great Falls team was featured in an article in the winter 2010 Signature Montana, the link is: http://www.signaturemontana.com/UserFiles/File/Winter10%20To%20Your%20Health%20LR(1).pdf

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	72.4	72.6	72.8	88.6	88.6
Annual Indicator	71.6	71.6	88.6	88.6	88.6
Numerator	250	250			
Denominator	349	349			
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88.6	88.6	90	90	90

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
Children's Special Health Services (CSHS) continued to collaborate with and provide support to the three regional pediatric specialty clinics (RPSC) sites, and outreach sites. Pediatric rheumatology clinics were suspended in May of 2008 but restarted in July 2009. A new pediatric pulmonologist moved to Montana in July of 2009. CSHS staff prepared for changes to the Cystic Fibrosis Clinics.

CSHS maintained its current web site to provide information and links to important sites for parents and medical providers.

In July of 2008, CSHS was awarded an EHDI grant from Centers for Disease Control. The EHDI funds have, in part, been used to start the process of converting the the Child Health Referral and Information System (CHRIS) client server software application to a web application and updates continued this year. CHRIS is the CSHS client tracking software used by the MT School for Deaf and Blind (MSDB) and the RPSC for tracking infants and young children, identified through universal newborn hearing screening to have significant hearing loss requiring services from MSDB. This shared software application now provides electronic referrals between programs and facilitates coordination of client services The Montana Medical Genetics program began accessing CHRIS to facilitate tracking of genetic clinic schedules, as well as newborn screening follow-up services..

CSHS staff continued to participate in the Medicaid targeted case management (TCM) work to ensure a funding source for public health home visiting to children and youth with special health care needs (CYSHCN). The CSHS manager conducted TCM billing training.

Discussions continued with Parents, Let's Unite for Kids (PLUK) as to how to maximize service delivery and health care coverage in Montana.

CSHS maintained financial support for the three RPSCs that served 2913 children, which is a 5% increase in the number of clients served from the previous year. Two reservation cleft/craniofacial clinics located in Wolf Point and Browning served 23 clients. The RPSCs continued to grow in numbers served and types of specialty clinics provided. There were 3333 clinic visits during FFY 2009, which is a 13% increase in the number of kids served from the previous year. Epilepsy, Synergis, and orthopedic clinics were added at the Missoula site. The pediatric clinic was also re-instituted in Missoula. The Great Falls site added orthopedic clinics.

CSHS continued ongoing evaluation of the services provided at the RPSC sites with Client/Parent Surveys and exit interviews. This information is used for coordinator training, informing the Advisory Sub-committee, clinic providers, and the CSHS staff with client/parental insights on improving clinic services. The client satisfaction survey done April-July 2009 at the RPSC for Cystic Fibrosis (CF) Clinic clients revealed very high satisfaction with clinic services. Families reported traveling between 1 and 350 miles to attend CF clinic.

CSHS continued in their role as a network provider whereby CSHS directly bills approximately 30 insurance companies, such Blue Cross Blue Shield, Aetna, CIGNA, and United Health Care for allowable procedures completed at the RPSC. This additional revenue is allocated to the RPSC in their yearly CSHS contracts and funds the Cleft/craniofacial and Metabolic inter-disciplinary clinics.

CSHS continued active outreach to other public and private agencies that provide services to CYSHCN. Staff completed community visits to Bozeman, Helena, and Great Falls and explained the CSHS services to hospital discharge staff, public health nurses, Newborn Intensive Care Units/nursery staff, and Part C early intervention staff. CSHS continues active outreach by attending the Spring Public Health Conference, the MT Public Health Association Conference, and pediatric and diabetes conferences.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHS will maintain its current web site to provide information and links to important sites for parents and medical providers			X	X
2. CSHS staff will continue to participate in the Medicaid TCM work to assure a funding source for public health home visiting to CYSHCN.				X
3. CSHS plans to continue contacting payers that are not reimbursing clinic visits, with the intent to increase payments.				X
4. Ongoing financial support, training and consultation for Regional Pediatric Clinic sites.		X		X
5. Continue partnership with Parents Lets Unite for Kids (PLUK)				X
6. CSHS will continue to bill for CF inter-disciplinary clinic and use the funds to support CSHS regional team clinics.			X	
7. CSHS will continue to assess and survey access to pediatric specialty care.		X		
8.				
9.				
10.				

b. Current Activities

CSHS welcomed a pediatric neurologist, a hospitalist/pediatric pulmonologist, and a metabolic geneticist to the state.

CSHS worked with Healthy MT Kids Plus (HMKP/Medicaid) to provide information about the availability of pediatric services in Montana. Medicaid, CHIP, and CSHS continued to work to coordinate services between out of state facilities and Montana providers.

CSHS contracted with a nurse who is working with Blue Cross Blue Shield of MT, the Medicaid Health Improvement Program (HIP) and Seattle Children's Hospital, focusing on the CYSHCN that are receiving services outside MT, discharge planning, and linking patients to local health departments.

Shodair provided clinical genetics services in 80 outreach clinics so the 76% of families that reside outside the Helena are could receive some services locally.

Individuals with metabolic conditions identified by newborn screening are seen in regional clinics which are staffed by Shodair in cooperation with local resources. Shodair also works with county health departments across Montana to coordinate services for clients in their communities.

CSHS continues contacting payers that are not reimbursing clinic visits in order to increase payments. CSHS also continues to support CF inter-disciplinary clinics.

CSHS is participating on the board for the Pediatric Epilepsy Telehealth grant which will provide pediatric follow-up neurological care to children.

c. Plan for the Coming Year

Shodair, the vendor for the newborn screening follow-up services and clinical genetics, will continue to provide outreach clinics and will increase efforts to measure the number of families that report community based services are organized so they can be easily utilized.

In an effort to continue the growth of CSHS team clinics, CSHS will continue ongoing payment negotiations with health care coverage payers with the intent to increase payments used to support clinic activities. CSHS staff will continue to work to achieve Blue Cross Blue Shield of MT support for cystic fibrosis inter-disciplinary clinic.

CSHS will continue to collaborate with Parents Let's Unite for Kids (PLUK), the MT Family Voices agency, to share data and information regarding opportunities for families to receive support, education or information about services.

The Montana Cleft/craniofacial Clinic Program is conducting two quality assurance activities related to cleft/craniofacial clinics in Montana. One of the studies is looking at the reporting rate of cleft lip and palate on birth certificates; the second is analyzing speech outcomes for children after palate surgery. An oral cleft fact sheet will be printed and distributed during in late 2010. This will be used for parent education and outreach.

A rack card handout is being developed for parents of babies in Newborn Intensive Care Units to increase parent awareness of services available in the state.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6.5	46.5	46.5
Annual Indicator	5.4	5.4	46.2	46.2	46.2
Numerator	8	8			
Denominator	147	147			
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	46.5	46.5	47.5	47.5	47.5

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
With input from the Children's Special Health Services (CSHS) Advisory Committee, CSHS planned to develop a standard transitional care questionnaire for use at the regional pediatric specialty clinics (RPSC). This questionnaire would have focused on the medical transition from childhood to adulthood, including managing the condition, obtaining health coverage, accessing services, and following through with treatment plans. This goal was not accomplished due to lack of staff resources.

A bureau staff member served on the advisory board of the Montana Transition Training, Information, and Resource Center (MT-TIRC). Some of the projects that were developed during the year included a series of twelve web-based conferences available to young people with disabilities and their families which provided information on topics such as self advocacy and customized employment, and an emerging leaders and mentors program. The Board's mission was to provide trainings and resources to prepare young people and their families before transition and to make the transition process less cumbersome. The information from board meetings was shared with the CSHS staff.

Resources were identified for possible adaptation for Montana, including those from The National Alliance to Advance Adolescent Health as well as the National Secondary Transition Technical Assistance Center.

CSHS staff and the RPSC coordinators acknowledged that transition is something to prepare for. Therefore, each RPSC encouraged transition and independence stages as each family and child is capable through one-to-one discussions with youth and family.

MT Metabolic Day, an education and networking day for clients and families was held in August 2009. The program provided networking opportunities for adults with metabolic conditions to interact with children and families regarding transition issues.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Provide limited support to youth receiving financial assistance for Children's Special Health Services (CSHS) and at regional clinic visits regarding health care transitions		X		
2. Offer financial support and information to pre-teens and teens for peer educational opportunities				X
3. Communicate and provide input to the MT-TIRC Advisory Board				X
4. Continue Metabolic Day opportunities for families dealing with metabolic conditions.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Shodair saw 57 youth 14-18 at 63 genetics clinic appointments where they received transition information about education, employment, medical care & living arrangements.

A second annual Montana Metabolic Day is scheduled for August 2010.

The cystic fibrosis (CF) survey information has been made available to the clinic coordinators and CF clinic social workers. Fifty-five percent reported they were not receiving social security disability and thus Medicaid coverage. Survey results show that more education needs to be done about health care coverage for transition.

A FCHB staff member remains a member of the MT-TIRC Advisory Board. The Board continues to be made up of at least 50% young people (ages 13-30). Activities from last year continue. A moderated online mentoring forum and MySpace & Face Book pages have been developed to reach youth looking for transition information.

A FCHB staff member attended the 2009 Youth Transitions Conference. Many transition related topics were covered such as the Social Security System, the Vocational Rehabilitation Program, the Work Incentives Planning and Assistance Program, assistive technology, & transition assessments for Individualized Educational Plans.

The CSHS supervisor met with the Administrator of the Disability Services Division in April of 2010 to learn how CSHS could be more of a presence and voice for transition services in MT. CSHS is aware of 60 national centers dealing with transition.

c. Plan for the Coming Year

Shodair will continue to work with youth aged 14-18 on issues related to transition to adulthood. Shodair hired a clinical psychologist in June of 2010. This addition to the team will be available for testing and referrals to further assist this age group in transitioning to adulthood.

Shodair will continue to provide all patients at the inter-disciplinary metabolic clinics with information and resources that will assist with transition.

CSHS staff will continue to send transition information with CSHS financial assistance applications and provide information to families regarding transitioning from health care programs such as Medicaid and CHIP to other payment sources.

The MT-TIRC Advisory Board's future is unsure at this point because 2010 is the third and final year of grant funding to support the board. Grant managers and board members are actively searching for new funding sources to continue the activities of the board, and the FCHB staff member will continue to serve on the board if board activities continue.

Financial support will be offered to the three parent representatives on the CSHS Advisory

Committee and a FCHB staff member to attend approved transition related trainings and conferences.

Communication with health care payers, CHIP and Medicaid, including Early Periodic Screening, Diagnosis and Treatment (EPSDT) will continue about the importance of assessing, ensuring and the need to measure the efforts to deliver transition services that apply to all aspects of CYSHCN adult life, health care, work, and independence.

CSHS will continue communicating with other CYSHCN state programs and Association of Maternal & Child Health Programs (AMCHP) about challenges and opportunities. CSHS will also continue to assess options and review partnerships with national centers dealing with transitions.

Taking the advice of other states, CSHS will explore the transition efforts and programs other existing agencies are conducting in MT. For example, CSHS will assess what the Federally Qualified Health Centers (FQHCs) are doing to assist CYSHCN to achieve independence and access to health care.

CSHS will begin contract negotiations with the regional providers in the summer of 2010. Transition is one of the items where CSHS will request more assessment and assurance that the activity is occurring.
CSHS will connect with the School Administrators of MT (SAM) and explore partnership opportunities ensuring educational functions for CYSHCN.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	91	80	80	80	80
Annual Indicator	79.6	73.6	75	65.5	53.4
Numerator	12952	12231			
Denominator	16271	16618			
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	70	70	70

Notes - 2009
The source of data is the National Immunization Survey (NIS), July 2008-June 2009 Table Data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0809.htm). The data for 2009 are not yet final. Please note that the 95% confidence interval for this indicator is +/- 7.0.

Notes - 2008
The source of data is the National Immunization Survey (NIS), July 2007-June 2008 Table Data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0708.htm). The data for 2008 are not yet final. Please note that the 95% confidence interval for this indicator is +/- 6.7.

Notes - 2007
The source of data is the National Immunization Survey (NIS), 2007 data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2007.htm). Please note that the 95% confidence interval for this indicator is +/- 6.2. A numerator and denominator were not readily available for this data, therefore none are included. These data were updated with final 2007 data for the July 15, 2009 submission.

A survey of providers indicates that the average vaccination rate among children who are able to access a provider is 81.2%. This rate includes Varicella as one of the antigens. The series evaluated in the 2007 provider survey was 4DTaP: 3Polio: 1MMR: 3Hib: 3HepB: 1Varicella. Using a census estimate of 11430 two year olds in the state, this survey would indicate that 9,281 children who were seen by providers had completed their immunizations by the end of their second year.

An electronic immunization registry was established in Montana several years ago. Participation in the registry has been gradually increasing since its inception. Until the statewide registry is more complete, Montana will continue to use the NIS as the source of data. According to the NIS survey, 65.3% (+/- 6.9) of two year olds had completed the series of 4DTaP: 3Polio: 1MMR: 3Hib: 3HepB: 1Varicella. Using the same census estimate, this would indicate 7,795 children were up to date by the end of their second year. The NIS survey includes children who may not have a medical home.

a. Last Year's Accomplishments
The 2009 legislature appropriated $400,000 for purchase and outreach of all adolescent vaccines.
The Montana Immunization Program continued to encourage and support vaccination activities throughout the state, including:
1) Increasing varicella vaccinations, especially prior to day care attendance, and improving varicella surveillance.
2) Increasing Tdap/Td booster rates for children in grade 7 by encouraging active participation of school nurses and administrators, and public health nurses.
3) Increasing the DTaP immunization rate among 2-year olds.
4) Providing educational brochures regarding HPV for girls ages 9 -- 18 to schools for distribution to the parents.
5) Conducting Regional Immunization Workshops for Local Health Jurisdictions to provide updates and training.
6) Encourage testing of all pregnant women for Hepatitis B infection during every pregnancy and reporting of positive test results to state or local health departments for case management and follow up.

Provider use of WIZRD continued to increase. The electronic import of immunization records from the Indian Health Service are currently conducted weekly by one Tribal Health Department. Work continued on establishing a Memorandum of Understanding with a second tribal health department.

Twenty-seven counties selected NPM 07 as their focus and conducted activities to help improve immunization rates in their counties.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided educational brochures regarding HPV for girls ages 9 -- 18 to schools for distribution to the parents		X		
2. Conducted Regional Immunization Workshops for Local Health Jurisdictions				X
3. Encouraged testing of all pregnant women for Hepatitis B infection			X	
4. Provider use of WIZRD continued to increase				X
5. The electronic import of immunization records from the Indian Health Service were conducted weekly by one Tribal Health Department				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Immunization activities continue to address a number of the immunization requirements for children. These include:

1) varicella vaccinations for day care attendance

2) improved varicella surveillance: including using WIZRD data to review histories of chickenpox infection and concentrating efforts during outbreaks on adolescents and younger children without 2 doses of the varicella vaccine

3) focusing on the Tdap/Td booster rates for children in grade 7 to decrease the number of pertussis cases in the school setting by encouraging active participation with school nurses and administrators, and local public health nurses; and 3) providing educational brochures regarding adolescent vaccines, including Tdap, meningococcal and HPV, to schools for distribution to parents

4) improving the DTaP immunization rate among 2 year olds to lessen the impact of pertussis on local communities.

Regional Immunization Workshops for Local Health Jurisdictions will be conducted during the coming year. These annual workshops are provided in each of Montana' five regions and provide trainings on new information and update information from previous trainings.

c. Plan for the Coming Year

The FCHB will develop an Immunization Activity Guide with best practices to improve immunization rates at local health departments.

The Public Health Home Visiting (PHHV) program assesses whether infants in the program receive their two, four and six month immunizations and the PHHV provider counsels the parent on the importance of continuing scheduled immunizations for the infant.

The CYSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources. Interdisciplinary teams staffed by a pediatrician and/or public health nurse will review immunization status. This would include cystic fibrosis clinics and cleft/craniofacial clinics. Care coordination is used to support families in accessing services.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS, Immunization Section will partner with 57 contractors to improve the immunization rate in Montana. Contractor activities will consist of:

- Maintaining immunization records in the statewide immunization registry system.
- Coordinating and providing outreach and referrals for children identified by immunization information systems who are behind in their immunizations.
- Developing and implementing a protocol for reducing missed opportunities for vaccination (eg. Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
- Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
- Meeting quarterly with local vaccinations for children (vfc) providers to review the data reports provided by department of public health and human services (dphhs) and share best practices for increasing immunization rates.
- Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
- Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
- Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
- Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
- Promoting delivery of vaccination services to underinsured adolescents.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	9.6	17	16	16
Annual Indicator	17.0	17.6	16.8	18.6	18.6
Numerator	349	359	343	367	367
Denominator	20551	20424	20388	19782	19782
Data Source				Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17	17	16	16	16

Notes - 2009

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
The numerator is the number of live births reported to the Montana Office of Vital Statistics for 15-17 year old female Montana residents in 2008. The denominator is the latest mid-year population estimate (May 2009 release) for females ages 15-17 in Montana in 2008.

Notes - 2007
The 2007 data were updated for the July 15, 2009 MCHBG submission with final vital statistics data and the updated (as of May 2009) census estimates.The numerator is births that occurred to MT residents 15-17 years of age in 2007. The denominator is the mid-year census estimate of females 15-17 years old in Montana (May 2009 release).

a. Last Year's Accomplishments
Pregnancy prevention was identified as a need by adolescents in the 2005 Maternal and Child Health Needs Assessment. The Women's and Men's Health Section (WMHS) maintained contracts and provided technical assistance to 14 Delegate Agencies (DAs) offering services in 28 locations serving all 56 counties in MT. Three WMHS staff members served as state level contacts for technical assistance and data related issues.

The DAs ensured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, educational information and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on family size and income, also ensured the affordability of these reproductive health services and supplies.

In the 2009 fiscal year, DAs served an estimated 7,433 adolescents and also provided specific outreach projects designed for adolescents considered at high risk for teen pregnancy and birth.

The WMHS received a 5 year grant from the Department of Health and Human Services Office of Population Affairs (DHHS OPA) to increase male services. The funds enabled the DAs to evaluate what strategies were needed to create a more male friendly environment and ways to market services to males. In 2009, the DAs reported an overall 9% increase in male patient numbers.

WMHS distributed special initiative funding from DHHS OPA to the Bridger Clinic for their Partners in Prevention Project. Bridger Clinic collaborated with several agencies to provide additional comprehensive sex education and family planning services to teen mothers and fathers and other at risk youth for teen pregnancy. With the assistance of 30 peer health educators Bridger Clinic reached over 1500 teens with pregnancy prevention information.

WMHS received a DHHS OPA Expansion Grant to increase patient numbers statewide. The grant supplemented the DAs ability to expand services in underserved communities targeting low income women and men, including adolescents.

The Health Education Specialist (HES) organized the statewide campaign for Teen Pregnancy Prevention Month in May. Outreach packets were created that included a press release, sample letters to the editor, posters, and educational brochures and distributed them to the DAs.

The Nurse Consultant, a member of a Region VIII Regional Training Advisory Council (RTAC), participated in RTAC's yearly planning meeting for selecting DA's trainings. The RTAC reviewed the Region VIII Title X Programs' Training Needs Assessment that is conducted biannually, and selected trainings that included education and clinical components.

The Health Education Specialist, a member of the State Family Planning Information and Education Committee (SPIEC), consisting of DA staff, met and reviewed and approved family

planning materials and identified priorities for all DAs. The SPIEC identified Teen Pregnancy Prevention Month as a priority and continued to coordinate a statewide outreach campaign.

WMHS created an on-line newsletter that includes information on funding opportunities, upcoming trainings and events, and pertinent information for Title X agencies.

HES attended the Reproductive Health Update Conference in Park City, UT in April 2009, and sent out updates through the WMHS weekly newsletter

WMHS produced an Annual Report that included information about the importance of family planning, Title X patient numbers, births averted, and specific information on each county. To access the online report: http://www.dphhs.mt.gov/PHSD/Women-Health/documents/AnnualReport2009.pdf

The HES assisted Planned Parenthood of Montana (PPMT) in establishing a statewide teen pregnancy prevention coalition. The first meeting of the coalition was September 14, 2009 which created subcommittees to coordinate efforts to address teen pregnancy in Montana.

Two counties selected NPM 08 as their focus and conducted activities to help improve the teen birth rates in their counties.

The rate of teen births in Montana has not decreased significantly in recent years.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WMHS continued to provide reproductive health services, technical assistance, and educational and outreach materials.	X		X	X
2. WMHS distributed an on-line newsletter for all the DA's, to provide updated information on teen pregnancy rates and other related information			X	X
3. Met and discussed materials and family planning priorities with the SPIEC				X
4. WMHS distributed a Teen Pregnancy Prevention Report in coordination with MCH Epidemiologist			X	
5. WMHS sought out additional funding opportunities for DA's to provide reproductive health services	X		X	X
6. WMHS provided training to DA's through annual training opportunities			X	X
7.				
8.				
9.				
10.				

b. Current Activities
WMHS contracts with 14 DAs, representing all 56 MT counties. The DAs provide reproductive health services, technical assistance, and educational and outreach materials to residents.

WMHS Program Specialist (PS) coordinates with HES, and MCH Epidemiologist to distribute information to local DAs on current teen pregnancy rates and trends in the 2009 Annual Report and Fall 2010 Teen Pregnancy Report.

SPIEC meets on a yearly or as needed basis to review and to plan family planning priorities:

Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and the "I Know" Campaign through outreach campaigns and toolkits provided by HES.

HES meets with RTAC, evaluating DAs and Region VIII Title X agencies training needs, and the March 2010 Training focused on adolescents, clinicians, and front desk staff. HES participated in Region VIII training on Reproductive Health Education in April 2010.

OPA funding is distributed to DAs for expanding male services; the Bozeman Teen Outreach & Pregnancy Prevention Project; dispensing highly effective & emergency contraceptives; and expanding services targeting low income women and men, including adolescents.

WMHS continues to coordinate efforts with PPMT's teen pregnancy coalition. Staff is represented on each subcommittee to address and reduce teen pregnancy.

WMHS disseminates information through the on-line newsletter including funding opportunities, upcoming trainings and events, and information for Title X agencies.

c. Plan for the Coming Year

WMHS intends to contract with the 14 Delegate Agencies to provide reproductive health services, technical assistance, and educational and outreach materials to residents that represent all 56 counties in MT.

The State Family Planning Information and Education Committee (SPIEC), facilitated by the WMHS Health Education Specialist will continue their yearly meetings focusing on promoting Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and the "I Know" Campaign through statewide outreach campaigns. Toolkits will be developed and disseminated to all DA's.

WMHS nurse consultant will continue to meet with the Regional Training Advisory Council to evaluate training needs for delegate agencies and Region VIII Title X agencies. The May 2011 conference will focus on topics identified by Title X agencies in the training needs assessment.

WMHS continues to coordinate efforts with PPMT's teen pregnancy coalition. Staff is represented on each subcommittee to address and reduce teen pregnancy.

The HES and PS, with the assistance of the MCH epidemiology unit, is currently updating the Trends in Teen Pregnancy Report for Fall 2010.

WMHS continues to disseminate information through the on-line newsletter that includes information on funding opportunities, upcoming trainings and events, and pertinent information for Title X agencies.

WMHS applied for a grant to provide reproductive health services to decrease unintended pregnancies among teens. If the grant is awarded in September 2010 will be working with DA's. This is a 5 year grant opportunity to provide Long Acting Reversible Contraceptives (LARC) to teens.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	40	40	40	46	46
Annual Indicator	33.2	45.9	45.9	45.9	45.9
Numerator	3413	4693	4693	4805	4773
Denominator	10295	10225	10225	10468	10398
Data Source				05 06 Statewide OH Study, OPI 3rd Grade Enrollment	05 06 Statewide OH Study, OPI 3rd Grade Enrollment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	46	46	46	46	46

Notes - 2009
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2008-2009 school year from the Montana Office of Public Instruction.

Notes - 2008
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2006-2007 school year, from the Montana Office of Public Instruction.

Notes - 2007
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2005-2006 school year, from the Montana Office of Public Instruction.

a. Last Year's Accomplishments
The Family and Community Health Bureau (FCHB) hired a health education specialist whose duties included promoting oral health education activities.

Access to Baby Child Dentistry (ABCD) training was offered to 77 dental health professionals in May 2009. ABCD was a collaborative effort involving FCHB, the Montana Dental Association (MDA), and the Primary Care Association (PCA).

Quarterly meetings were held with the Montana (MT) Primary Care Association (PCA) to discuss oral health related needs. Five Community Health Centers (CHC) began offering the ABCD Program on April 1, 2009, with the first monthly training provided in June 2009.

The FCHB queried the Fluoride Mouth Rinse (FMR) stakeholders for input on the FMR Transition

Plan which was approved by the Family Health Advisory Committee (FHAC) at their April 2009 meeting. The FMR Plan recommended that due to budgetary constraints the FMR program end at the close of the 2008-09 School Year.

The FMR Transition Plan also supported the ABCD Program, continued oral health education in schools and pursuing additional oral health funds. The FMR program ended on 6/30/09.

The FCHB did not receive the grant for Improving Children's Oral Health in MT.

The draft summary report on the Montana 2005-2006 study of oral health needs among 3rd graders and Head Start children was completed and reviewed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Family and Community Health Bureau (FCHB) hired a health education specialist		X	X	
2. Access to Baby Child Dentistry (ABCD) training was offered to 77 dental health professionals			X	X
3. Quarterly meetings were held with the Montana (MT) Primary Care Association (PCA) to discuss oral health related needs				X
4. The FCHB queried the Fluoride Mouth Rinse (FMR) stakeholders for input on the FMR Transition Plan				X
5. The draft summary report on the Montana 2005-2006 study of oral health needs among 3rd graders and Head Start children was completed and reviewed				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Funding was available for the MT ABCD Partnership Program through Dec. 31, 2009. The FCHB Epidemiology Unit analyzed the data and a final report will be written by the FCHB.

The summary report on Montana's "2005-2006 Oral Health Study for Montana's Third Grade and Head Start Children" is being finalized and will be distributed to oral health stakeholders. It will also be available to the public on the FCHB Oral Health website.

School-specific reports on school-based oral health screenings conducted in 2004-2010 are currently being drafted and will be distributed to schools and oral health screeners.

The FCHB Oral Health (OH) program produced oral health educational materials which provide age-appropriate materials for teachers of children in grades 1--5. Each section focuses on one grade level and provides a summary of objectives and resources as well as talking points, handouts, coloring pages, games, illustrations, and lessons. Topics include the importance of teeth and oral hygiene, tooth development, tooth decay and prevention, and nutrition.

The FCHB OH program submitted a grant proposal to HRSA for developing a 5-year strategic plan (which will include implementing school-linked sealant programs) and increasing the dental workforce in Montana.

The FCHB offers the Open Wide program (online oral health education program) to child care providers and school nurses. In SFY09 over 83 participants have received this training and over 10,866 toothbrushes were distributed.

c. Plan for the Coming Year

The FCHB will continue to seek funding to implement school-linked dental sealant/varnish programs.

The FCHB OH program will continue to review and update educational materials. The materials will be promoted in communications to school nurses, public health partners, school officials and other interested parties.

The FCHB OH program will work closely with counties which select National Performance Measure (NPM) 09 to increase the number of 3rd graders receiving protective sealants on permanent molars.

The FCHB will continue to offer the Open Wide program which provides oral health education to child care providers and school nurses. Upon completion of the Open Wide program, the FCHB will again offer free toothbrushes for the children in the care of the participants.

The FCHB will release a report summarizing the accomplishments and challenges of the ABCD program. Individual reports will be available for the participating health centers and a comprehensive report will be released to the general public.

The summary report on Montana's "2005-2006 Oral Health Study for Montana's Third Grade and Head Start Children" will be finalized and distributed to oral health stakeholders, oral health partners, Head Start/Early Head Start programs and other interested parties. It will also be available to the public on the FCHB Oral Health website.

School-specific reports on school-based oral health screenings conducted in 2009-2010 will be distributed to participating schools and oral health screeners.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.5	4.4	4.3	4	6
Annual Indicator	6.2	6.2	5.6	6.2	6.2
Numerator	11	11	10	11	11
Denominator	177051	177559	177577	178508	178508
Data Source				MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	6	6	5	5

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal.

Notes - 2008
Denominator data are from the updated July 1, 2008 census estimates for the population of 0-14 year olds in Montana (May 2009 release). Numerator data are the number of deaths to Montana residents 14 and under due to motor vehicle crashes, as reported to the Montana Office of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

Notes - 2007
Denominator data are from the updated July 1, 2007 census estimates for the population of 0-14 year olds in Montana (May 2009 release). Numerator data are from final vital statistics data for 2007 (updated for the July 15, 2009 submission) and include deaths to resident 0-14 year olds that occurred in Montana and elsewhere and were reported to the MT Office of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

a. Last Year's Accomplishments
Local Fetal Infant Child Mortality Review (FICMR) Teams reviewed child deaths and implemented community activities related to prevention of motor vehicle deaths.

The Family and Community Health Bureau (FCHB) sustained FICMR activities with several training opportunities. The FICMR coordinator training, held February 2009, included FICMR review basics, determining preventability of deaths, death certificate information and a mock case review for 13 attendees. During this face-to-face meeting, there was discussion on the current review tool, how to keep local team members involved and an open discussion on prevention activities and lessons learned. The attendees were allowed the opportunity to ask questions about the mortality review process and how to submit a FICMR review.

The FICMR Coordinator attended the quarterly Emergency Medical Services for Children (EMSC) Advisory Meetings and provided FICMR information. EMSC prevention information related to prevention was shared with local FICMR coordinators.

The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, "A Summary of Mortality Reviews Conducted in 2005-2006." The report, which highlighted evidenced-based best practices and prevention activities in Montana including youth suicide, was distributed to the local FICMR coordinators and is available online on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-index.shtml

The FICMR and EMSC state coordinators attended a National Symposium of State Leaders in Maternal Child Health, Injury Prevention and Child Death Review, "Keeping Kids Alive," on May 20-22, 2009 in Washington DC. Montana specific information, i.e. graduated drivers license, car seat safety education, check stations, firearm deaths and information related to the review of youth fatalities from motor vehicle accidents was highlighted in the presentation for Montana.

The Department of Public Health and Human Services' (DPHHS) request from the 2009 Legislature for general funds supporting a State Injury Prevention position was approved. This position is housed in the Chronic Disease Bureau.

The FICMR Coordinator initiated a monthly electronic newsletter in August, 2009 that was sent to the local FICMR coordinators. The September, 2009 issue included information on National Child Passenger Safety Week and links to websites emphasizing motor vehicle safety, All Terrain Vehicle (ATV) safety, and additional prevention ideas and activities.

Four counties selected NPM 10 as their focus and conducted activities to help decrease the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

The rate of deaths due to motor vehicles among children 14 years and younger continues to hover around 6 per 100,000. Motor vehicle deaths are one of the leading causes of death for Montanans of all ages, and they become the leading cause and outpace other causes around 6-12 years of age.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local Fetal Infant Child Mortality Review (FICMR) Teams reviewed child deaths and implemented community activities related to prevention of motor vehicle deaths			X	
2. The Family and Community Health Bureau (FCHB) sustained FICMR activities with several training opportunities			X	X
3. The FICMR Coordinator attended the quarterly Emergency Medical Services for Children (EMSC) Advisory Meetings and provided FICMR information				X
4. The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, “A Summary of Mortality Reviews Conducted in 2005-2006.”			X	X
5. The FICMR and EMSC state coordinators attended a National Symposium of State Leaders in Maternal Child Health, Injury Prevention and Child Death Review, “Keeping Kids Alive				X
6. The Department of Public Health and Human Services’ (DPHHS) request from the 2009 Legislature for general funds supporting a State Injury Prevention position was approved				X
7. The FICMR Coordinator initiated a monthly electronic newsletter			X	
8.				
9.				
10.				

b. Current Activities
The FICMR Coordinator is available as a resource via phone, email, traditional mail or in person and shares pertinent prevention information, current journal articles and information received from national sources related to infant and child death prevention with the local coordinators. The FICMR Coordinator participates on a number of committees, i.e. Injury Prevention Coalition and the EMSC, each charged with addressing preventable injuries.

The FICMR Coordinator continues to maintain contact with local FICMR coordinators. Local FICMR meetings allow the local coordinators an opportunity to network, share prevention

activities and collaborate on lessons learned with their peers, thereby improving the sense of teamwork and effectiveness of FICMR efforts.

The FCHB Epidemiologist works with the FICMR Coordinator on a process to review FICMR data on an annual basis, facilitating earlier identification of preventable deaths and earlier implementation of prevention activities. The FCHB assists the local FICMR teams in understanding their data findings and incorporating them into community level prevention activities.

The FCHB promotes prevention strategies statewide by distributing the 2005-2006 FICMR Report, "A Summary of Mortality Reviews Conducted in 2005-2006" which includes community prevention activities. The full report is available on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-index.shtml

c. Plan for the Coming Year

The Infant Child & Maternal Health Section (ICMHS) will now be a part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The FICMR Coordinator position will remain active and will report to the MCHC Section Supervisor. The FICMR Coordinator will continue to support state and community FICMR injury prevention efforts by providing twice a year educational meetings/trainings and continuing as a resource via phone, email or in-person contact. Current journal articles and information related to infant and child death prevention (including information related to motor vehicle safety, car seat and seat belt use) will be sent electronically to local coordinators.

The FICMR Coordinator will continue to attend quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The FICMR Coordinator will share prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities.

The FICMR Coordinator will utilize conference calls for local FICMR coordinator trainings and meetings. This will allow for the potential of increased participation in meetings due to decreased travel time and time away from local offices.

The FICMR Coordinator will collaborate with local coordinators, MCHC Supervisor, and FCHB Epidemiologist to evaluate the use of a National Child Death Review (CDR) Data reporting tool.

Local FICMR Teams will continue to review child deaths and implement community activities related to preventability of motor vehicle deaths.

The State FICMR Team will no longer meet due to budget cuts.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		26	29	54	54
Annual Indicator	25.9	49.3	52.1	52.9	56.8
Numerator	3184				
Denominator	12283				

Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	57	57	57	58	58

Notes - 2009
The data reported for 2009 are National Immunization Survey data for children born in 2006. The data are not yet final. The confidence interval for this indicator is +/- 7.6.

Notes - 2008
The data reported for 2008 are National Immunization Survey data for children born in 2005. The data are final. The confidence interval for this indicator is +/- 6.1.

Notes - 2007
The data source for this measure is the National Immunization Survey (NIS). The breastfeeding results are reported by year of the infant's birth. In this case, the data are for infants born in 2004. The confidance interval for this indicator is +-5.9. In previous years WIC data were used to report on this measure, but the NIS were considered a better source of population-level data. The 2006 indicator was updated with final NIS data for the July 15, 2009 submission. The objective for 2007 was set based on WIC data, not NIS data, and so is not a good match with the indicator.

a. Last Year's Accomplishments
WIC's effort to increase breastfeeding and reduce the risk of obesity continued by providing financial, technical assistance and training support to the Ravalli, Deer Lodge, Cascade, Custer and Missoula/Salish and Kootenai Tribes Breastfeeding Peer Counselor Projects (BPCP). These WIC Programs served approximately 1,200 pregnant and breastfeeding women per month.

Four of the BPCP were monitored during the year. One finding required corrective action at one BPCP. A second BPCP decided to make changes in their operations prior to the monitoring visit, but had not completed them by the visit. The changes were completed after the monitoring visit.

The WIC Breastfeeding Coordinator (BC) continued her involvement with the Montana State Breastfeeding Coalition (MSBC), but as other work commitments related to the new computer system arose, MSPIRIT, she was not able to participate as much as the prior year.

The WIC electronic communication system worked very well. Trainings and conferences on breastfeeding or related topics were included for local staff. A breastfeeding training workshop was announced in the electronic WIC Newsletter. Two state staff including the BC, several local WIC program staff from other areas and other local health department staff attended the training workshop. Additionally, the local WIC program and the hospital staff spent additional time working on networking and planning how to coordinate and inform clients/patients of each other's breastfeeding services.

Two staff from a local program with a BPCP represented Montana WIC at the Mountain Plains Regional Office Loving Support Breastfeeding Train-the-Trainer Training in July 2009. They presented information from the WIC Training in August 2009 at the Spring Public Health

Conference (SPHC).

Since Montana started using the NIS data to monitor rates of breastfeeding at 6 months, the rate has remained at around 50%. Due to small sample sizes for Montana, the NIS data tend to have fairly large confidence intervals, so differences between the years do not appear to be significant. Although the rate for 2006 births (reported as 2009 data) appeared to increase, the increase is not significant. With the passing of legislation supporting breastfeeding spaces in state government offices during the 2007 legislative session, breastfeeding has gained some additional attention in the state. Montana's rate of breastfeeding at 6 months appears to be high compared to the national rate as measured in the NIS, although the confidence intervals overlap somewhat. Montana's rate for breastfeeding is higher than the US rate.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued Breastfeeding Peer Counselor Funding, Tech Assist to Locals	X			
2. Monitoring of Four BPCP				X
3. Involvement with MT State Breastfeeding Coalition				X
4. Use of in-house newsletter to communicate training opportunities				X
5. Determined standards for new automated system and breastfeeding dyad food package assignment				X
6. Training on new food package including new breastfeeding food packages and relationship of breastfeeding level and supplemental formula, Loving Support (breastfeeding support)				X
7. Ordered breast pumps for distribution by local programs		X		
8.				
9.				
10.				

b. Current Activities
MSPIRIT was rolled out and training was held for local program staff. During the SPHC, program directors attended a session on reporting functions.

The new WIC food packages were implemented this year. MSPIRIT links the breastfeeding dyad and food packages being issued. Montana is working to implement redemption of the fruit and vegetable benefit at farmers' markets. Work to develop a nutrition education tool kit emphasizing farmers' markets will be completed in mid-spring.

Two local program staff provided a train-the-trainer at the SPHC on USDA's "Loving Support" breastfeeding training, designed to build staff competencies to promote and support breastfeeding in association with the changes to the breastfeeding dyad food packages.

Additional funding for the BPCP was received and four projects were funded. Each BPCP was awarded an additional $2,500 for education/training.

The BC will continue to participate in the MSBC and plans to attend the U.S. Breastfeeding Committee's biennial conference. Local program staff will be encouraged to participate in the MSBC.

The breastfeeding reports available in MSPIRIT will be reviewed and explained to local programs staff. Gaps in desired information will be assessed and additional reports will be evaluated for

feasibility by the MSpirit Users Group.

The BC attended the United States Breastfeeding Coalitions 3rd National Conference of State/Territory/Tribal Breastfeeding Coalitions in January 2010.

c. Plan for the Coming Year
At least two more BPCP will be added to the existing programs. A call for proposals will be made early in FFY 2011. Awardees will be notified by the first quarter of FFY 2011. Use of any remaining FFY 2010 funds will be reviewed and a plan made to utilize the funds.

Additional training on the information from the "Loving Support Grow and Glow" materials will continue to be provided to local staff. A session will be planned for the 2011 Spring Public Health Meeting WIC Day.

Training for Breastfeeding Peer Counselors (BPC) and their supervisors is planned for November 30 and December 1, 2010. The keynote presentation will address how all clinic staff have a role in promoting breastfeeding. A sharing session of activities and projects from the local BPCP and a segment on current system reports are planned. Other topics will be arranged.

The breastfeeding reports available in the MSPIRIT automated system will be reviewed and explained to the staff of local WIC programs. Gaps in desired information will be assessed and additional reports will be evaluated for feasibility by the Spirit Users Group.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	92	92	94	94
Annual Indicator	87.9	90.0	93.1	93.0	93.9
Numerator	10157	11107	11403	11669	11463
Denominator	11551	12339	12249	12551	12204
Data Source				MT newborn hearing screening system, Hi-Track	MT newborn hearing screening system, Hi-Track
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94	94	95	95	95

Notes - 2009
The numerator data source for this measure is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from the Montana Office of Vital Statistics and includes births to Montana residents that occured in Montana in 2009. It does not include births to Montana residents that occurred out of state.

Notes - 2008
The numerator data source for this measure is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from the Montana Office of Vital Statistics and includes births to Montana residents that occured in Montana in 2008. It does not include births to Montana residents that occurred out of state. 12,178 (97%) of Montana's calendar year 2008 birth cohort were born in hospitals, approximately 2.5% were born with professional attendants, and .5% were born at home without professional attendants. Of those born in hospitals, 96% were screened prior to hospital discharge.

Notes - 2007
The numerator data source for this is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from vital stats and includes births to Montana residents that occured in Montana in 2007. It does not include births to Montana residents that occurred out of state.

a. Last Year's Accomplishments
Montana's Universal Newborn Hearing Screening and Intervention (UNHSI) program is based on the national "1-3-6" program standard: newborn screening completed by one month of age; needed audiologic assessment completed by no later than three months of age; and, appropriate early intervention before six months of age. The scope of the program includes both the Department of Public Health and Human Services and the Board of Public Education, as well as the cooperation of local hospitals, midwives, and audiologists.
The UNHSI manager continued to provide monthly e-mail and telephone technical assistance to hospitals, audiologists, and midwives to ensure compliance with the state law adopted in February 2008 concerning newborn hearing screening (NBHS) by hospitals, midwife education of parents about the crucial importance of NBHS for all babies born outside of hospitals, and reporting of pediatric audiologic assessments. The manager provided monthly feedback to hospitals on population-based matching of birth certificates with screening records, provided a list of babies needing repeat outpatient screening, required documentation in the tracking software of the name of the primary care professional (PCP) for every baby who completed NBHS without a Pass result, the date the PCP was informed of that screening result, and monitored that all required data elements were included in each record submitted in the tracking software. A letter was sent to the primary care physician of each baby who completed NBHS without a Pass result and contact information for the five audiologists who are qualified to perform a complete pediatric audiologic assessment was enclosed. The Hearing Conservation Program audiologists under contract with the Office of Public Instruction (OPI) have continued to provide free newborn hearing screening to babies born outside of hospitals in accordance with the on-going agreement established by the UNHSI program manager with OPI. All babies diagnosed as deaf or hard of hearing were electronically referred by the UNHSI manager to the Montana School for the Deaf and Blind for Early Intervention services.

The manager publicized the NBHS Percent Complete in calendar year 2009 for each hospital with birthing services in rank order grouped in five categories depending on size of annual birth cohort. This has proven to be a powerful motivator for ensuring that sufficient resources are dedicated to performing, recording and reporting screening results to the state program. SEE ATTACHMENT

The manager also provided feedback to the midwives on how well they complied with reporting requirements for the education they must provide to their clients about the importance of NBHS before each newborn is one month old. The manager provided the local screening partners with

NBHS brochures, posters, rack cards, and screening report forms containing milestones for language development to be given to the parents prior to discharge. Approved state educational brochures and/or rack cards were also distributed to pediatricians and family practice doctors, as well as to midwives. Grant funds were used to run the NBHS 30-second advertising spot on cable television for five weeks in the seven largest service areas in Montana on Discovery, Food Network, USA, Lifetime, and The Learning Channel.

The Montana School for the Deaf and Blind (MSDB) and the UNHSI program continued to work closely to ensure that the babies identified as deaf or hard of hearing are referred to the school for monitoring and provision/coordination of intervention services. Children's Special Health Services (CSHS and the MSDB use the same software to record and track services provided to children with special health care needs, including those who are deaf or hard of hearing.

CDC Early Hearing Detection and Intervention (EHDI) program support continued to provide intensive quality assurance on-site contact over the three-year period of 2008 through 2011 with all local partners who screen, assess, and provide parental education about newborn hearing screening and assessment. The funding has also enabled to the conversion of the software used by the state to track diagnoses, continuing assessments and intervention services into a system providing web-based, role-defined access to mutual client records by professionals serving deaf or hard of hearing children.

The percent of newborns screened for hearing continues to increase.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn hearing screening data with matched newborn bloodspot testing data and birth certificate data.				X
2. Continue to contract for Help Desk technical assistance for use of the tracking software by birthing facilities and audiologists.				X
3. Track newborn hearing screening and audiological assessment results from the tracking software and communicate the results to screening and assessment partners statewide.			X	
4. Electronically refer infants diagnosed as deaf or hard of hearing to the Montana School for the Deaf and the Blind within six months of each child's birth.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The primary focus for calendar year 2010 will be to continue the technical and programmatic support of the local screening and assessment partners in the statewide UNHSI program to ensure the achievement of the "1-3-6" program standard. Special emphasis is being placed on implementing techniques to reduce lost-to-follow-up (LTFU) occurrences in those hospitals with less than 95% completion of NBHS.

The UNHSI manager continues to contact primary care professionals to provide the contact information for the five audiologists who are qualified to perform a complete pediatric audiologic assessment to assist the provider in reaching the state UNHSI three-month assessment program

goal.

The UNHSI manager continues to make electronic referrals of all babies diagnosed as deaf or hard of hearing to the Montana School for the Deaf and Blind as required in state law.

The UNHSI manager continues to provide local program partners with educational brochures, rack cards and screening results reporting forms for parents that include milestones for language development.

CSHS program staff provided intensive quality assurance (QA) and training on-site contact in May, June and July of 2010 with local partners who screen and/or assess hearing and provide parental education about newborn hearing screening and assessment. The on-site QA reviews include examination of both a random sample of baby medical records for a full calendar year and of the local implementation of the programmatic standards.

c. Plan for the Coming Year

The program will continue to explore the efficacy of loaning newborn hearing screening equipment to midwives serving populations with the lowest level of newborn hearing screening participation.

A survey of parents who refused newborn hearing screening for their babies born in calendar year 2010 will be conducted to determine whether the 30-second TV spot will need to be further modified to address misconceptions about the need for newborn hearing screening.

The UNHSI manager will continue to provide monthly technical assistance to hospitals, audiologists, and midwives to ensure compliance with the state law adopted in February 2008 concerning newborn hearing screening (NBHS) by hospitals, midwife education of parents about the crucial importance of NBHS for all babies born outside of hospitals, and reporting of pediatric audiologic assessments.

The manager will continue to provide monthly feedback to hospitals on population-based matching of birth certificates with screening records and a list of babies needing repeat outpatient screening.

The UNSHI manager will continue to work cooperatively with the Early Hearing Detection and Intervention (EHDI) Coordinators in neighboring states to obtain screening and assessment results for babies born in Montana and transferred to out-of-state hospitals.

The program manager will continue to contact the primary care physician of each baby who completed NBHS without a Pass result and provide contact information for the Montana audiologists who are qualified to perform a complete pediatric audiologic assessment. The cooperation of the Hearing Conservation Program audiologists under contract with the Office of Public Instruction (OPI) to provide free newborn hearing screening to babies born outside of hospitals will continue in accordance with the on-going agreement.

All babies diagnosed as deaf or hard of hearing will continue to be electronically referred by the UNHSI manager to the Montana School for the Deaf and Blind for Early Intervention services.

EHDI funding will allow the completion of the conversion of the CHRIS software used by the state to track diagnoses, continuing assessments and intervention services into a system providing web-based, role-defined access to mutual client records by professionals serving deaf or hard of hearing children.

The manager will publicize the NBHS Percent Complete status for calendar year 2010 for each

hospital with birthing services in rank order grouped in five categories depending on size of annual birth cohort.

The program in Montana is currently solely funded with two federal grants, both of which conclude in 2011: HRSA UNHSI funding ends March 31, 2011; CDC EHDI funding ends June 30, 2011. The program anticipates applying for continued funding to maintain support of the local partners in their on-going efforts to comply with state law concerning newborn hearing screening, assessment and referral for appropriate early intervention services.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	16	16	14	13
Annual Indicator	17.0	16.2	14.8	14.2	11.9
Numerator	38755	37000	35686	34417	28863
Denominator	227972	228000	241206	242716	241672
Data Source				US Census CPS Table Creator II	US Census CPS Table Creator II
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	11	11	10	10

Notes - 2009
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2009 for health insurance coverage in 2008. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

Notes - 2008
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2008 for health insurance coverage in 2007. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

Notes - 2007
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2007 for health insurance coverage in 2006. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

a. Last Year's Accomplishments
CHIP provided quality, comprehensive insurance coverage for Montana children.

In November 2008, Montana residents passed Initiative 155, which established the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid

and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids was implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level. CHIP and Medicaid continued to provide quality, comprehensive insurance coverage for Montana children as they worked on implementing the expanded coverage. The new program was expected to not only greatly increase the number of children in the state with health insurance, but also to reduce the number of children who fall through the gaps between Medicaid and CHIP eligibility. Healthy Montana Kids was intended to facilitate continuous coverage of children whose families are under 250% of the federal poverty level, whereas previously coverage may have fluctuated if children's eligibility shifted from Medicaid to CHIP or vice versa.

The percent of children without health insurance appears to be gradually decreasing.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHIP provided quality, comprehensive insurance coverage for Montana children		X		
2. Montana residents passed Initiative 155, which established the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHIP and Medicaid continue their efforts to increase the number of children enrolled in the Healthy Montana Kids program. Children with health coverage have greater access to preventive and acute health care services. Both parties continue to work towards their shared goal of improving the health of Montana children.

c. Plan for the Coming Year

CHIP and Medicaid will continue their efforts to increase the number of children enrolled in the Healthy Montana Kids program. Both parties will continue to work towards their shared goal of improving the health of Montana children.

The FCHB will use the National Survey of Children's Health to establish a baseline for any local health departments selecting National Performance Measure 13. The FCHB will also assist any local health departments selecting this performance measure in developing and implementing activities which will increase the percentage of children with health insurance and/or participating in Healthy Montana Kids.

Twice a year, the Primary Care Office (PCO) will provide National Health Services Corp contact information to the Primary Care Association (PCA) who in turn will distribute this information to families and other partners. The contact information includes how to apply for Healthy Montana Kids.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	30	30	29
Annual Indicator	26.6	32.5	33.6	33.7	33.3
Numerator	3447	3629	3706	3876	3957
Denominator	12936	11169	11029	11492	11878
Data Source				WIC Program Enrollment	WIC Program Enrollment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	31	31	31	31	31

Notes - 2009
The source is from the MT State WIC Program. Data are for FFY 2009.

Notes - 2008
The reported denominator and numerator includes all children ages 2-5 enrolled in WIC during '08 starting 01/01/08 and ending 12/31/08. The numerator reflects all children with risk codes 16 and 17.

Although there was a fairly large increase in the percent of children ages 2 to 5 years receiving WIC services with BMI at or above 85th percentile from 2005 to 2006, since then there have been smaller but steady percentage increase reported by the WIC Program. The large change from 2005 to 2006 could be related to changes in the way the data are collected.

Notes - 2007
The reported denominator and numerator includes all children ages 2-5 enrolled in WIC during '07 starting 01/01/07 and ending 12/31/07. The numerator reflects all children with risk codes 16 and 17.

a. Last Year's Accomplishments
Local WIC staff collected children's weight and height measurements at each certification, which determined the child's body mass index (BMI). Parents of a child determined to be overweight or obese status were provided additional WIC counseling as requested by the family at future WIC appointments.

The Value Enhanced Nutrition Assessment (VENA) questions were created and placed into MSPIRIT, the new computer system. VENA questions to be addressed elicited information about the parents' perception of the infant's/child's growth, physical activity, feeding behaviors and foods/beverages consumed. These questions were discussed at each certification visit.

The five Breastfeeding Peer Counselor Projects (BPCP) were funded and operated throughout

the year. In July, two local program staff attended train-the-trainer training for USDA's "Loving Support", designed to build staff competencies to promote and support breastfeeding in association with the changes to the breastfeeding dyad food packages. They presented this training to local program staff.

The WIC food budget allowed for an additional order of multi-user breast pumps, which were made available to local WIC programs. Several types of breast pumps were ordered and received. The emphasis of the order was to increase our supply of multi-user breast pumps.

The WIC Futures Study Group continued to meet and provided suggestions to the state as to how to increase WIC participation i.e. mini-grants to local programs for outreach activities. The Food Package Task Force (FPTF) met and worked on training materials and methods for grocers and participants for the new WIC food package.

WIC distributed the monthly Eat Right Montana (ERM) Newsletter to the 27 locals who in turn were encouraged to incorporate the newsletter in their press releases and to use the materials as a nutrition education resource.

The Breastfeeding Coordinator (BC) participated in the Chronic Disease/Obesity Prevention Task Force. A partnership with the Nutrition and Physical Activity Program (NAPA) to work on breastfeeding activities was achieved. This partnership continued with both parties involved in the Montana State Breastfeeding Coalition (MSBC). The Montana State Breastfeeding Coalition continued to operate as a subcommittee of Eat Right Montana (ERM). THE BC participates in both the MSBC and ERM.

The new WIC approved foods and food packages were finalized. They followed more closely the 2005 Dietary Guidelines. Significant changes included a reduction of the amount of fat in the food package, an increase in the number of offered whole grains, and the addition of fresh fruits and vegetables. Participants had the option to redeem their fruit and vegetable benefit check for purchasing fresh fruits and vegetables and frozen vegetables at Farmers' Markets or grocery stores. See the attachment: New WIC Food Package.

A WIC Futures Study Group (WFSG), composed of lead local public health officials, local program, and state WIC Staff, was formed during 2008 and met two times this year. The WFSG discussed a number of topics including, the current and future WIC funding allocation formula, program direction, and how to provide quality WIC services into the future. For additional information, please see http://www.dphhs.mt.gov/PHSD/family-health/nutrition-wic/WIC-futures-studygroup.shtml.

One county selected NPM 14 as its focus and conducted activities to help reduce the percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Since reporting on this indicator began in 2005, the percent of WIC participants ages 2-5 with a BMI at or above the 85th percentile has increased.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local staff weigh and measure infant and child participants	X			
2. VENA questions determined and incorporated into automated system				X
3. Continued funding for BPCP	X			
4. Training of staff on Loving Support (breastfeeding support)				X

5. WIC Futures Study Group activities				X
6. Distribution of ERM Healthy Families Newsletter			X	
7. Involvement with Chronic Disease/Obesity Task Force and with the MT State Breastfeeding Coalition				X
8. Train staff on significant changes to new food packages, less fat, more whole grains, fruits, vegetables and fiber				X
9.				
10.				

b. Current Activities

The new WIC food packages, which are intended to follow more closely the 2005 Dietary Guidelines, were implemented this year. A committee was formed of interested parties to make recommendations for implementing the redemption of the fruit and vegetable benefit at local farmers' markets.

Work is proceeding on the WIC Farmers' Market Infrastructure grant.

MSPIRIT has been implemented.

Additional funds were received for the Breastfeeding Peer Counselor Projects this year. Six programs expressed interest in establishing a BPCP. Three, Gallatin, Flathead and Riverstone were awarded grants.

A WIC infrastructure grant was received for the promotion of fruits and vegetables for WIC participants. Through a contractor, the "What Incredible Choices Toolkit" was created. The toolkit was presented to WIC staff during the SPHC.

WIC developed a combined program for the redemption of WIC fruit and vegetable benefits and WIC Farmers' Market Nutrition Program benefits called Farm Direct (FD). Participants can use either benefit for approved FD foods at any authorized farmer as any location the farmer operates and sells their produce. This increases the options for fresh fruits and vegetables for participants

The WIC Director and a WIC Public Health Nutritionist provided input for the 2011 -- 2020 Montanan Nutrition and Physical Activity (NAPA) State Plan to Prevent Obesity.

Research into resources to be used in training staff on VENA competencies was not completed.

c. Plan for the Coming Year

WIC will pursue funding to develop an activity toolkit for use by local WIC staff, for children under age 5 served by WIC.

A new Sesame Street Health Habits kit focusing on activity will be available in early fall. WIC will pursue funding for the purchase of these kits. If funding is found they will be provided with guidance to local WIC programs.

FD will be promoted next year and local WIC programs who did not participate last year will be encouraged to investigate options for the program in their area.

Since WIC was not able to complete the research for resources for training staff on VENA competencies, it is planned for the upcoming year. These materials will be used for new staff and reviewed for current staff. State Plan policies and procedures will be reviewed for the MSPIRIT implementation and updated to reflect VENA within the new system to provide more participant-centered nutrition education.

Work is proceeding on the WIC Farmers' Market Infrastructure grant. A contractor has been hired to prepare the nutrition education materials and other materials are being selected and purchased. These materials will be released in the fall of 2010.

A session on MSPIRIT will be presented to agency directors on the reporting capabilities of MSPIRIT at the next Spring Public Health Conference (SPHC). The session will focus on the enhanced capacity to extract information to more accurately track this performance measure and other data for reports.

The two local staff members who attended the train-the-trainer training by USDA on "Loving Support" will provide a half day training on the WIC Day at the next SPHC. This will give WIC staff another tool to promote and support breastfeeding and reduce the risk of obesity.

Additional funds were received for the Breastfeeding Peer Counselor Projects this year. Six programs expressed interest in establishing a BPCP. Three, Gallatin, Flathead and Riverstone were awarded grants. WIC will continue communication with other programs which were not funded. Northern Cheyenne is in the process of negotiations for this year. Silver Bow will be delayed due to staffing until next fiscal year. Lewis and Clark decided to withdraw this year, but indicated their interest to apply next fiscal year.

A WIC infrastructure grant was received for the promotion of fruits and vegetables for WIC participants. Through a contractor, the "What Incredible Choices Toolkit" was created. The toolkit was presented to WIC staff during the SPHC. A thermal bag with a matching graphic, a cookbook for fresh produce and grant funds were provided to local WIC programs to use in the promotion of fruits and vegetables. WIC will continue to promote this toolkit.

The WIC Director and a WIC Public Health Nutritionist provided input for the 2011 -- 2020 Montanan Nutrition and Physical Activity (NAPA) State Plan to Prevent Obesity. WIC staff will discuss with NAPA a possible project for local WIC programs.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		15	15	14	14
Annual Indicator	15.9	15.9	15.9	15.0	15.0
Numerator	1668	1668	1668	1893	1893
Denominator	10509	10509	10509	12595	12595
Data Source				Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	14	13	13	13	13

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
These data are collected and reported by trimester of pregnancy, not month of pregnancy. 2008 is the first year smoking status has been available from the birth record by time period of pregnancy. The numerator and denominator include births to Montana residents that were reported to the Montana Office of Vital Statistics. This number is believed to be an under-report of the actual number of women smoking during the last trimester.

Notes - 2007
The numerator and denominator are from the 2002 PRAMS data collected from mothers in a Point-In-Time (PIT) state sample. This is the only source of population-level data available on maternal smoking during the last three months of pregnancy. Vital statistics currently does not collect data on maternal cigarette smoking by gestational age.

A new birth certificate will be implemented in 2008 and will include a question on smoking prior to pregnancy and by trimesters of pregnancy. This is expected to provide a new source of data for this performance measure as of the 2010 MCHBG application.

a. Last Year's Accomplishments
The Family and Community Health Bureau (FCHB) staff collaborated with Montana Tobacco Use Prevention Program (MTUPP) and produced a webinar training for Public Health Home Visiting (PHHV) providers and other public health providers on smoking cessation.

Sixteen PHHV sites and six Enhanced PHHV sites were funded. The Family and Community Health Bureau (FCHB) staff provided standardized training on the PHHV assessment tools to the local PHHV providers.

The Enhanced Projects continued to include a support specialist who provided Intensive Case Management to those women at highest risk of substance use during pregnancy.

The FCHB coordinated the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breast feeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

The PHHV reassessment process helped redefine data elements and how data related to smoking cessation was collected. Beginning July 1, 2009, a different method of reporting tobacco use was implemented to provide more accurate data on this measure.

The FCHB collaborated with PHHV projects to implement the electronic transfer of data elements from the local level to the state level. Staff implemented revisions to the standard software and coordinated software training for local PHHV site staff to capture smoking behavioral data.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. See: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

One county selected NPM 15 as its focus and conducted activities to help reduce the percentage of women who smoke in the last three months of pregnancy.

2008 is the first year Montana has had data on smoking during the last trimester from the birth record. Additional years of data from this same source will indicate the trend in smoking. The 2002 PRAMS estimate of smoking during pregnancy was 15.9%. The birth record data is believed to be an underreport of the actual rate of smoking during pregnancy.

The overall prevalence of smoking during pregnancy is 17% and the rate has not decreased over the last decade.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The FCHB staff collaborated with MTUPP and produced a webinar training for PHHV providers and other public health providers on smoking cessation				X
2. Sixteen PHHV sites and six Enhanced PHHV sites were funded	X		X	
3. The Enhanced Projects continued to include a support specialist who provided Intensive Case Management to those women at highest risk of substance use during pregnancy	X			
4. The FCHB coordinated the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements				X
5. The PHHV reassessment process helped redefine data elements and how data related to smoking cessation was collected				X
6. The FCHB collaborated with PHHV projects to implement the electronic transfer of data elements from the local level to the state level				X
7. The FCHB developed a PHHV Report summarizing key program outcomes				X
8.				
9.				
10.				

b. Current Activities

The FCHB continues to fund 16 PHHV programs, which promote the Montana Tobacco Quit Line through information and referrals for pregnant women and infant/family units.

Funding for the six enhanced PHHV sites ended in December 2009.

The PHHV home visitor assesses and monitors the High Risk Pregnant Woman's (HRPW) smoking and other tobacco use status at each face-to-face contact. PHHV clients receive information on the effects of tobacco during pregnancy from the PHHV home visitor.

PHHV sites began entering PHHV client data elements into the common electronic data system as of July 1, 2009. Data on outcomes related to pregnant women smoking, other tobacco use, cessation and referrals to cessation resources is being collected by all of the PHHV sites.

In January and February 2010, FCHB and MTUPP staff collaborated to offer three smoking cessation webinars to PHHV and other public health staff across Montana.

The 16 PHHV sites are being monitored at least once a year by the FCHB staff through on-site visits. The sites are being monitored for their compliance with program requirements and the FCHB staff provides technical assistance as needed. A site visit audit form has been developed and is being used on site visits. A written report of the site visit findings is being sent to each PHHV site.

c. Plan for the Coming Year

The Infant Child & Maternal Health Section (ICMHS) will now be a part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The PHHV Nurse Consultant position will remain active and will report to the MCHC Section Supervisor. The PHHV Nurse Consultant will continue to support state and community PHHV efforts by serving as a resource via phone, email or in-person contact. Current journal articles and information related to smoking cessation during pregnancy will be sent electronically to PHHV home visitors.

The FCHB will continue to fund 16 PHHV programs, which promote the Montana Tobacco Quit Line through information and referrals to their pregnant women and infant/family units. The PHHV home visitors will also refer their clients to other community cessation programs as needed.

All the PHHV sites will be monitored at least once a year by the PHHV Nurse Consultant and FCHB staff through on-site visits. The sites will be monitored for their compliance with program requirements and the FCHB staff will provide technical assistance as needed. A site visit audit form which includes tobacco use assessment has been developed and will be used on site visits. A written report of the site visit findings will be sent to each PHHV site.

The PHHV currently assesses tobacco use during pregnancy at outcome as required by the Request for Proposal (RFP) which sunsets in FFY2012. The FCHB will review the RFP and evaluate the feasibility of changes that require the PHHV home visitor to assess and monitor the High Risk Pregnant Woman's (HRPW) smoking and other tobacco use status at intake, at each face-to-face contact and at outcome.

The PHHV clients will receive information from the PHHV home visitor on the effects of tobacco and secondhand smoke during pregnancy and on the infant.

PHHV sites will enter PHHV client data elements into the common electronic data system. Data on outcomes related to pregnant women using tobacco products, cessation of tobacco use, and referrals to cessation resources will be collected by all of the PHHV sites. Quality assurance checks will be conducted and site-specific reports will be compiled.

The PHHV Nurse Consultant will collaborate with MTUPP to provide webinar training for PHHV staff and other public health staff on tobacco cessation strategies for pregnant women.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	10	9	9
Annual Indicator	26.4	19.2	16.3	11.9	11.9
Numerator	18	13	11	8	8

Denominator	68097	67811	67574	67074	67074
Data Source				MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	11	10	10	10

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
The numerator include deaths to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator data is from 2008 census estimates for the population of 15-19 year olds in the state (May 2009 version). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

Notes - 2007
Death records from the Montana Office of Vital Statistics are the source of the numerator data. 2007 vital statistics data were finalized for the July 2009 submission and include suicide deaths to MT residents, regardless of place of occurrence. Denominator data are from the 2007 census estimates for the population of 15-19 year olds in the state (May 2009 estimates). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

a. Last Year's Accomplishments
Local Fetal Infant Child Mortality Review (FICMR) teams reviewed child deaths and implemented community activities related to prevention of youth suicide.

The Family and Community Health Bureau (FCHB) sustained FICMR activities with several training opportunities. The FICMR coordinator training, held February 2009, included FICMR review basics, determining preventability of deaths, death certificate information and a mock case review for 13 attendees. During this face-to-face meeting, there was discussion on the current review tool, how to keep local team members involved and an open discussion on prevention activities and lessons learned. The attendees were allowed the opportunity to ask questions about the mortality review process and how to submit a FICMR review.

The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, "A Summary of Mortality Reviews Conducted in 2005-2006." The report, which highlighted evidenced-based best practices and prevention activities in Montana including youth suicide, was distributed to the local FICMR coordinators and is available online on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-index.shtml

A FCHB staff member served as a representative on the Planting Seeds of Hope (PSOH) Technical Advisory Board, provided updates to the PSOH Board and reported back current

activities of the PSOH projects to local FICMR coordinators and other interested parties.

The FCHB collaborated as requested or as needed with the Statewide Suicide Prevention Coordinator on efforts to prevent youth suicide in Montana. The Statewide Suicide Prevention Coordinator is a member of the State FICMR Team and was invited to attend meetings and provide updates on youth suicide prevention activities in Montana.

Three counties selected NPM 16 as their focus and conducted activities to help reduce the rate of suicide deaths among youths aged 15 through 19.

The rate of suicide deaths among youth appears to be decreasing.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local Fetal Infant Child Mortality Review (FICMR) teams reviewed child deaths and implemented community activities related to prevention of youth suicide			X	
2. The Family and Community Health Bureau (FCHB) sustained FICMR activities with several training opportunities			X	X
3. The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, "A Summary of Mortality Reviews Conducted in 2005-2006."			X	X
4. FCHB staff member served as a representative on the Planting Seeds of Hope (PSOH) Technical Advisory Board				X
5. The FCHB collaborated as requested or as needed with the Statewide Suicide Prevention Coordinator on efforts to prevent youth suicide in Montana				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FICMR Coordinator is available as a resource via phone, email, traditional mail or in person. The FICMR Coordinator shares pertinent prevention information, current journal articles and information received from national sources related to infant and child death prevention with the local coordinators via email. The FICMR Coordinator participates on a number of committees, i.e. Injury Prevention Coalition and the Emergency Medical Services for Children (EMSC), each charged with addressing preventable unintended injuries.

Local FICMR teams continue to review child deaths and implement community activities related to prevention of youth suicide.

The FCHB collaborates as requested or as needed with the Statewide Suicide Prevention Coordinator on efforts to prevent youth suicide in Montana.

The FCHB has a representative on the Planting Seeds of Hope (PSOH) Technical Advisory Board and will provide FCHB updates to the PSOH Board and report back on PSOH current activities and projects to FCHB, local FICMR coordinators and other interested parties.

c. Plan for the Coming Year

The Infant Child & Maternal Health Section (ICMHS) will now be a part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The FICMR Coordinator position will remain active and will report to the MCHC Section Supervisor. The FICMR Coordinator will continue to support state and community FICMR injury prevention efforts by providing twice a year educational meetings/trainings and continuing to serve as a resource via phone, email or in-person contact. Current journal articles and information related to youth suicide prevention will be sent electronically to local FICMR coordinators.

The FICMR Coordinator will continue to attend quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The State FICMR Coordinator will share prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities.

The FICMR Coordinator will continue utilizing conference calls for local FICMR coordinator trainings and meetings.

MCHC staff will provide annual training updates to local FICMR coordinators on how to accurately complete the FICMR data reporting form to ensure consistency in all reviews. These training updates will be included in the local coordinator biannual meetings. The trainings will include case examples of incorrect form completion and mock reviews.

The current FICMR data collection and the National Child Death Review (CDR) database were reviewed and future FICMR reports will be evaluated using the National CDR database. FCHB plans on making the change during State Fiscal Year 2011 (SFY11).

The FICMR Coordinator will collaborate with local coordinators, MCHC Supervisor, and FCHB Epidemiologist to evaluate the use of a National Child Death Review (CDR) Data reporting tool.

Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of youth suicide. The State FICMR Team will no longer meet due to budget cuts.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	91	91	91	91
Annual Indicator	78.2	81.8	86.8	73.0	73.0
Numerator	97	126	138	108	108
Denominator	124	154	159	148	148
Data Source				Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events					

over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	76	76	77

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
The data source for this measure is live birth records from the Montana Office of Vital Statistics. In 2008, Montana had three level 3 facilities (facilities for high-risk deliveries). The numerator and denominator include births that occurred in Montana, regardless of the mother's place of residence.

Notes - 2007
The data source for this performance measure is the MT Office of Vital Statistics. In 2007, Montana had three level 3 facilities (facilities for high-risk deliveries and neonates). The numerator and denominator include infants born in Montana, regardless of the mother's place of residence.

a. Last Year's Accomplishments
Sixteen Public Health Home Visiting (PHHV) sites and six Enhanced PHHV sites were funded. The FCHB staff provided standardized training on the PHHV assessment tools to the local PHHV providers. The Family and Community Health Bureau (FCHB) staff provided standardized training on the PHHV assessment tools to the local PHHV providers.

The Enhanced Projects continued to include a support specialist who provides Intensive Case Management (ICM) to those women at highest risk of substance use during pregnancy.

The FCHB coordinated the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breast feeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

The PHHV reassessment process helped redefine data elements and how data related to smoking cessation will be collected. Beginning July 1, 2009, a different method of reporting tobacco use was implemented to provide more accurate data on this measure.

FCHB worked with PHHV projects to implement the electronic transfer of data elements from the local level to the state level. Staff implemented revisions to the standard software and coordinated software training for program staff.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. See: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

FCHB and Montana Tobacco Use Prevention Program (MTUPP) staff collaborated to provide tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana.

Work continued on revision of the Service Provision Assessment (SPA) and rules for Targeted Case Management (TCM) as part of the DPHHS TCM workgroup. A rate setting methodology

was explored, including a time study of local TCM providers.

The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates decreased in 2008, although the reasons for such a substantial decrease are unknown. 2008 birth record data are still preliminary. If the rate is still low after the data are final it may be useful to look at whether the 2008 very low birth weight deliveries had different characteristics that may relate to early indications of risk or access to facilities than very low birth weight births in previous years.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Sixteen Public Health Home Visiting (PHHV) sites and six Enhanced PHHV sites were funded	X		X	
2. The Enhanced Projects continued to include a support specialist who provides Intensive Case Management (ICM) to those women at highest risk of substance use during pregnancy	X			
3. The FCHB coordinated the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements				X
4. The PHHV reassessment process helped redefine data elements and how data related to smoking cessation will be collected				X
5. FCHB worked with PHHV projects to implement the electronic transfer of data elements from the local level to the state level				X
6. The FCHB developed a PHHV Report summarizing key program outcomes				X
7. FCHB and Montana Tobacco Use Prevention Program (MTUPP) staff collaborated to provide tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana				X
8. Work continued on revision of the Service Provision Assessment (SPA) and rules for Targeted Case Management (TCM) as part of the DPHHS TCM workgroup				X
9.				
10.				

b. Current Activities

The FCHB continues to fund the 16 PHHV programs which provide home visiting services for high risk pregnant women to promote the importance of early and adequate prenatal care to achieve healthy pregnancy outcomes.

Funding for the six enhanced PHHV sites ended in December 2009.

The PHHV home visitors assess and monitor the status of prenatal care during home visits and other face-to-face contacts with PHHV clients. PHHV home visitors provide the client with education on the importance of starting prenatal care during the first trimester and continuing prenatal care until birth of the baby.

All PHHV pregnant clients without health insurance coverage are assisted with the presumptive eligibility process, thus allowing her access to early prenatal care and/or referral to Medicaid by PHHV home visitor.

PHHV sites began entering client data into the common electronic data system as of July 1, 2009. Data on outcomes related to adequacy of prenatal care using the Kotelchuck Index and referrals to health care resources is being collected.

The FCHB staff collaborates with the following: March of Dimes Montana Chapter (to focus on prematurity prevention), the Family Planning Programs in Montana (to counsel and refer clients with positive pregnancy tests to early prenatal care), and WIC providers (to refer pregnant clients to PHHV services and early prenatal care if needed).

The 16 PHHV sites are being monitored at least once a year by the FCHB staff through on-site visits.

c. Plan for the Coming Year

The Infant Child & Maternal Health Section (ICMHS) will now be a part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The PHHV Nurse Consultant position will remain active and will report to the MCHC Section Supervisor. The PHHV Nurse Consultant will continue to support state and community PHHV efforts by serving as a resource via phone, email or in-person contact.

The FCHB will continue to fund 16 PHHV programs which provide home visiting services to high risk pregnant women and infants and promote healthy pregnancy outcomes.

The FCHB will collaborate with local public health providers, physicians, March of Dimes, Family Planning Programs, and other MCH partners on issues surrounding delivery of very low birth weight infants and to counsel and refer clients with positive pregnancy tests to health care resources.

All PHHV pregnant clients without health insurance coverage will be assisted by PHHV home visitors with the presumptive eligibility process for Medicaid, thus facilitating access to early prenatal care and other healthcare resources.

The PHHV home visitors will assess and monitor the status of prenatal care during home visits and other face-to-face contacts with PHHV clients. PHHV local project staff will promote the importance of early and adequate prenatal care to pregnant women and women of childbearing age in Montana. PHHV home visitors will provide the PHHV client with education on the importance of starting prenatal care as early as possible and remaining connected to systems of care throughout the pregnancy.

Montana has three Level III facilities, located in Great Falls, Missoula and Billings, for very low birth weight babies and high risk deliveries. The FCHB will begin linking PHHV client data to birth records to determine the percentage of low birth weight infants delivered at these facilities and establish a baseline percentage for Montana and PHHV clients.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	85.4	85.9	84.5	73

Annual Indicator	83.1	82.4	82.1	71.3	71.3
Numerator	9616	10302	10213	8982	8982
Denominator	11573	12499	12437	12595	12595
Data Source				Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	74	75	75	75	75

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
2008 data for this measure should not be compared to previous years. The data source for this measure is the Montana Office of Vital Statistics and includes births to MT residents reported to the MT Office of Vital Statistics. The decrease in the timing when prenatal care relates to changes in the way the data are collected on the new birth record format implemented in 2008. Also, 6% of records reported "unknown" timing of prenatal care initiation, a large increase from the approximately 2% unknown reported in previous years.

Notes - 2007
The data source for this performance measure is the Office of Vital Statistics, Montana DPHHS. Data reflect births to Montana residents, and were updated for the July 15, 2009 grant submission.

a. Last Year's Accomplishments
Sixteen PHHV sites and six Enhanced PHHV sites were funded. The Family and Community Health Bureau (FCHB) staff provided standardized training on the PHHV assessment tools to the local PHHV providers.

The Enhanced Projects continued to include a support specialist who provides Intensive Case Management (ICM) to those women at highest risk of substance use during pregnancy.

The FCHB coordinated the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breast feeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

The FCHB worked with PHHV projects to implement the electronic transfer of data elements from the local level to the state level. Staff implemented revisions to the standard software and coordinated software training for program staff. By using 2006 data, the FCHB developed a

PHHV Report summarizing key program outcomes. See: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

FCHB and Montana Tobacco Use Prevention Program (MTUPP) staff collaborated to provide tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana.

Work continued on revision of the Service Provision Assessment (SPA) and rules for Targeted Case Management (TCM) as part of the DPHHS TCM workgroup. A rate setting methodology was explored, including a time study of local TCM providers.

Targeted Case Management training was provided at the 2009 FCHB Spring Public Health conference. Information on billing procedures and Target Case Management (TCM) requirements was presented.

One county selected NPM 18 as its focus and conducted activities to help increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

A new birth certificate format was implemented in 2008. The substantial decrease in the percent of pregnancies with prenatal care initiation in the first trimester may relate to the new birth record format, as 11% of records reported "unknown" timing of prenatal care initiation, a large increase from the approximately 2% reported in previous years. However, among those pregnancies with known timing of prenatal care initiation (11068), 72.6% reported starting prenatal care in the first trimester, which is still lower than in previous years. The way this information was collected on the birth record changed in 2008, which may also be contributing to the difference. Prenatal care initiation early in pregnancy is now reported by date of first prenatal care visit, and a calculation is used to estimate the trimester of pregnancy. Previously, prenatal care initiation was collected by asking the month of pregnancy when prenatal care began.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Sixteen PHHV sites and six Enhanced PHHV sites were funded	X			
2. The Enhanced Projects continued to include a support specialist who provides Intensive Case Management (ICM) to those women at highest risk of substance use during pregnancy	X			
3. The FCHB coordinated the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements				X
4. The FCHB worked with PHHV projects to implement the electronic transfer of data elements from the local level to the state level				X
5. FCHB and Montana Tobacco Use Prevention Program (MTUPP) staff collaborated to provide tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana				X
6. Work continued on revision of the Service Provision Assessment (SPA) and rules for Targeted Case Management (TCM) as part of the DPHHS TCM workgroup				X
7. Targeted Case Management training was provided at the 2009 FCHB Spring Public Health conference. Information on billing procedures and Target Case Management (TCM)				X

requirements was presented				
8.				
9.				
10.				

b. Current Activities

Funding for the six enhanced PHHV sites ended in December 2009. The 16 PHHV sites are being monitored at least once a year by the FCHB staff through on-site visits. The sites are being monitored for their compliance with program requirements and the FCHB staff provides technical assistance as needed.

The PHHV home visitors assess and monitor the status of prenatal care during home visits and other face-to-face contacts with PHHV clients. PHHV home visitors provide the PHHV client with education on the importance of early and adequate prenatal care to achieve healthy pregnancy outcomes and continuing prenatal care until birth of the baby.

All PHHV pregnant clients without health insurance coverage are assisted with the presumptive eligibility process, thus allowing her to access early prenatal care and/or referral to Medicaid by PHHV home visitor.

PHHV sites began entering PHHV client data elements into the common electronic data system as of July 1, 2009. Data on outcomes related to adequacy of prenatal care using the Kotelchuck Index and referrals to health care resources is being collected.

The FCHB staff collaborates with the following: March of Dimes Montana Chapter (to focus on prematurity prevention), the Family Planning Programs in Montana (to counsel and refer clients with positive pregnancy tests to early prenatal care), and WIC providers (to refer pregnant clients to PHHV services and early prenatal care if needed).

c. Plan for the Coming Year

The Infant Child & Maternal Health Section (ICMHS) will now be a part of the Maternal and Child Health Coordination Section (MCHC) of the FCHB. The PHHV Nurse Consultant position will remain active and will report to the MCHC Section Supervisor. The PHHV Nurse Consultant will continue to support state and community PHHV efforts by serving as a resource via phone, email or in-person contact. Current journal articles and information related to the importance of early prenatal care will be sent electronically to PHHV home visitors.

The FCHB will continue to fund the 16 PHHV programs which provide home visiting services to high risk pregnant women to promote healthy pregnancy outcomes.

The PHHV home visitors will assess and monitor the status of prenatal care during home visits and other face-to-face contacts with PHHV clients and will promote the importance of early and adequate prenatal care to pregnant women and women of childbearing age in Montana. PHHV home visitors will provide the PHHV client with education on the importance of starting prenatal care as early as possible and continuing throughout the pregnancy.

The FCHB will collaborate with local public health providers, physicians, March of Dimes, Family Planning Programs, and other MCH partners on issues surrounding delivery of very low birth weight infants and to counsel and refer clients with positive pregnancy tests to health care resources.

All PHHV pregnant clients without health insurance coverage will be assisted by PHHV home visitors with the presumptive eligibility process for Medicaid, thus facilitating access to early prenatal care and other healthcare resources.

The FCHB will begin evaluating PHHV client data to determine the percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester and establish a baseline percentage for PHHV clients.

The FCHB will continue to communicate with Healthy Mothers Healthy Babies (HMHB) on using Text4Baby pending an evaluation of the efficacy of Text4Baby.

D. State Performance Measures

State Performance Measure 1: *Percent of unintended pregnancy among Title X clinic clients.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63	62	62	61	61
Annual Indicator	64.0	64.0	71.5	56.6	56.6
Numerator	1251	1281	1188	950	950
Denominator	1955	2002	1661	1677	1677
Data Source				Women's and Men's Health Program	Women's and Men's Health Program
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	60	60	60	

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal.

Notes - 2008
The denominator is the total Title X clients receiving a positive pregnancy test. The numerator is the total of these clients with unintended pregnancies.

Notes - 2007
The denominator is total Title X clients receiving a positive pregnancy test. The numerator is the total of these clients with unintended pregnancies.

a. Last Year's Accomplishments
Pregnancy prevention and birth control were identified as needs by adolescents and women, respectively, in the 2005 Maternal and Child Health Needs Assessment. The Women's and Men's Health Section (WMHS) of the Family and Community Health Bureau (FCHB) maintained contracts and provided technical assistance to 14 Delegate Agencies (DA) offering services in 28 locations serving all 56 counties in MT. These agencies ensured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, educational information, and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on family size and income, also ensured the affordability of family planning services and supplies. Go to: http://www.familyplanning.hhs.mt.gov

In state fiscal year 2009, the Delegate Agencies served 27,182 women and men. It is estimated that family planning services prevented approximately 17,725 unintended pregnancies and 2,517 abortions during this time.

DPHHS continues monitoring the 1115 Medicaid Waiver submitted on 7/1/08 to Centers for Medicare and Medicaid Services (CMS)

The intra-uterine device (IUD) referral system continued to allow rural Delegate Agencies, without the capacity to provide IUD insertions, the ability to refer these clients to larger agencies. In Fiscal Year '09, 97 low income women received IUD's.

The Nurse Consultant, a member of a Region VIII Regional Training Advisory Council (RTAC), participated in their yearly planning meeting for selecting DA's trainings. The RTAC reviewed the Region VIII Title X Programs' Training Needs Assessment that is conducted biannually, and selected trainings that included education and clinical components.

The WMHS Health Education Specialist (HES) is a member of the State Family Planning Information and Education Committee (SPIEC), consisting of delegate agency staff, that meets yearly. At their 2009 meeting, the SPIEC reviewed and approved materials and identified priorities for all delegate agencies. The SPIEC identified Teen Pregnancy Prevention Month as a priority and continued to coordinate a statewide outreach campaign. The HES also coordinates efforts with Planned Parenthood Montana's (PPMT) teen pregnancy coalition.

WMHS received Special Initiative funding from the Department of Health and Human Services (DHHS) Office of Population Affairs (OPA) that were distributed to Bridger Clinic for the Partners in Prevention Project. Bridger Clinic collaborated with several agencies to provide supplementary comprehensive sex education and family planning services to teen mothers and fathers and other at risk youth for teen pregnancy prevention.

The Office of Population Affair's (OPA) additional special initiative funds provided Delegate Agencies with funding for male clinic services, HIV testing and counseling, and funds to increase access to highly effective contraceptives as well as emergency contraceptives.

WMHS created an on-line newsletter that includes information on funding opportunities, upcoming trainings and events, and pertinent information for Title X agencies.

WMHS provided outreach materials, fact sheets, and an Annual Report on different topics. These included the 24-hour toll-free hotline number that provides information on the nearest Family Planning Clinic, pregnancy prevention and family planning services, to county Offices of Public Assistance, Healthy Mothers Healthy Babies (HMHB), Public Health Home Visiting Programs (PHHV),Women Infants and children WIC offices, 14 local Breast and Cervical Health Program sites (BCP), and Indian Health Services (IHS) as well as to the Delegate Agencies. http://www.dphhs.mt.gov/PHSD/Women-Health/documents/AnnualReport2009.pdf

WMHS received a Title X Expansion Grant to increase patient numbers statewide. The grant supplemented all 14 Delegate Agencies ability to expand services in underserved communities targeting low income women and men, including adolescents. Each DA submitted a work plan with strategies to market, increase clinic or clinician hours, or expand service to outlying areas to increase their patient load. In 2009 patients increased by 352 patients (1.3%). This is the first increase family planning has seen in four years.

One county selected SPM 01 as its focus and conducted activities to help reduce percent of unintended pregnancy among Title X clinic clients.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. WMHS Continues to provide reproductive health services, technical assistance, and educational and outreach materials.	X		X	X
2. WMHS distributes an on-line newsletter for all the DA's, to provide updated information on teen pregnancy rates and other related information			X	X
3. Meet and discuss materials and family planning priorities with the SPIEC				X
4. WMHS distributes a Teen Pregnancy Prevention Report in coordination with MCH Epidemiologist			X	
5. WMHS seeks out additional funding opportunities for DA's to provide reproductive health services	X		X	X
6. WMHS provides training to DA's through annual training opportunities			X	X
7.				
8.				
9.				
10.				

b. Current Activities

WMHS provides reproductive health services, technical assistance, and educational and outreach materials to the 14 DAs and partners: HMHB, PHHV sites, and WIC.

HES meet with RTAC, evaluating DAs and Region VIII Title X agencies training needs for each Annual Conference. HES attended Region VIII training on Reproductive Health Education in April 2010.

HES and Program Specialist (PS), with MCH epidemiology unit, is updating the Trends in Teen Pregnancy Report for Fall 2010.

DPHHS is monitoring the 1115 Medicaid Waiver (7/1/08) to CMS. The IUD referral system has allowed 97 low income women access to an IUD, and 10 qualified men and women received free sterilization.

The HES meets to discuss materials and priorities with the SPIEC and provide toolkits. Also continues to coordinate efforts with PPMT's teen pregnancy coalition. Staff is represented on each subcommittee to address and reduce teen pregnancy.

OPA distributes funding to DAs for male services; Bozeman Teen Outreach & Pregnancy Prevention Project; dispensing highly effective and emergency contraceptives; and expanding services to low income women and men, including adolescents.

WMHS disseminates information through the on-line newsletter including funding opportunities, upcoming trainings and events, and information for Title X agencies.

WMHS will coordinate with Foster Care, TANF, WIC and other state agenicies to develop policies and activities which will reduce the rate of teen pregnancy and births.

c. Plan for the Coming Year

The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of seven new state performance measures (SPM) to meet the needs of Montana's MCH population. These are:

SPM #1: The percent of children with cleft lip and/or palate receiving care in multidisciplinary clinics.

SPM #2: The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.

SPM #4: The rate of death to children 0 through 17 years of age caused by unintentional injuries (per 100,000).

SPM #5: The percent of women who smoke during pregnancy.

SPM #6: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis.

SPM #7: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Varicella.

This performance measure (SPM 01: Percent of unintended pregnancy among Title X clinic clients) will not be addressed as one of the state's seven performance measures and will be inactive at the beginning of FFY 2011.

State Performance Measure 2: *Percent of women who abstain from alcohol use in pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98.3	98.5	98	98
Annual Indicator	97.0	96.8	97.2	97.3	97.3
Numerator	11122	11988	11939	12109	12109
Denominator	11468	12388	12287	12446	12446
Data Source				MT Office of Vital Statistics	MT Office of Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	98	99	

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal.

Notes - 2008
The data source for this measure is live birth and fetal death records for events that occurred in Montana to Montana residents, as reported to the Montana Office of Vital Statistics. The numerator includes women who reported no alcohol use during pregnancy. The denominator includes all MT residents with a reported live birth or fetal death in Montana in 2008. Vital records data on alcohol use during pregnancy are based on self-report. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance.

Notes - 2007

Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2007 and reported not drinking alcohol during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2007 and reported not drinking alcohol during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2007. Vital records data on alcohol use in pregnancy is based on self-report. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance.

a. Last Year's Accomplishments
Sixteen PHHV sites (which included five Enhanced PHHV projects) and one Enhanced PHHV site (on a reservation) were funded. The Family and Community Health Bureau (FCHB) staff provided standardized training on the PHHV assessment tools to the local PHHV providers.

The Enhanced Projects continued to include a support specialist who provided Intensive Case Management to those women at highest risk of substance use during pregnancy.

The Public Health Home Visiting (PHHV) reassessment project resulted in the 5P's (Parents, Peers, Partner, Past, Pregnancy) screening tool for alcohol and drug use during pregnancy being implemented at the PHHV sites.

The PHHV reassessment project developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breast feeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

The PHHV reassessment process helped redefine data elements and how data related to alcohol and drug use were collected. Beginning July 1, 2009, a different method of reporting alcohol and illicit drug use was implemented to provide more accurate data on this measure.

FCHB collaborated with PHHV projects to implement the electronic transfer of data elements from the local level to the state level. Staff implemented revisions to the standard software and coordinated software training for local PHHV site staff to capture alcohol and drug use data.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. See: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml
FCHB staff and one local staff attended the Fetal Alcohol Spectrum Disorder (FASD) Center for Excellence, Building FASD State Systems (BFSS) meeting for states in May, 2009 in Albuquerque, New Mexico.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Sixteen PHHV sites (which included five Enhanced PHHV projects) and one Enhanced PHHV site (on a reservation) were funded	X			
2. The Enhanced Projects continued to include a support specialist who provided Intensive Case Management to those women at highest risk of substance use during pregnancy	X			
3. The Public Health Home Visiting (PHHV) reassessment project resulted in the 5P's (Parents, Peers, Partner, Past,	X			

Pregnancy) screening tool for alcohol and drug use during pregnancy being implemented at the PHHV sites				
4. The PHHV reassessment project developed a logic model for project evaluation and a standard set of data elements				X
5. The PHHV reassessment process helped redefine data elements and how data related to alcohol and drug use were collected				X
6. FCHB collaborated with PHHV projects to implement the electronic transfer of data elements from the local level to the state level				X
7. By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes				X
8. FCHB staff and one local staff attended the Fetal Alcohol Spectrum Disorder (FASD) Center for Excellence, Building FASD State Systems (BFSS) meeting for states				X
9.				
10.				

b. Current Activities

The FCHB funds 16 PHHV programs which promote abstinence from drinking alcohol at any time during pregnancy for pregnant women and infant/family units. The FCHB collaborates with community programs which provide resources on abstinence from alcohol for pregnant women and family units.

All the PHHV and Enhanced PHHV sites are being monitored at least once a year by the FCHB staff through on-site visits. The sites are being monitored for their compliance with program requirements and the FCHB staff provides technical assistance related to alcohol, tobacco and other drug use during pregnancy. A site visit audit form has been developed and is being used on site visits. A written report of the site visit findings is being sent to each PHHV site.

The PHHV home visitor assesses and monitors the High Risk Pregnant Woman's (HRPW) alcohol and drug use at each face-to-face contact. PHHV clients are screened for alcohol and illicit drugs using the 5P's screening tool, and monitored and referred as indicated. PHHV clients receive information on the effects of alcohol and drug use during pregnancy from the PHHV home visitor.

PHHV sites began entering PHHV client data elements into the common electronic data system as of July 1, 2009. Data on outcomes related to pregnant women using alcohol and/or drugs, abstinence from substance use, and referrals to abstinence resources in the community is being collected by all of the PHHV sites.

c. Plan for the Coming Year

The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of seven new state performance measures (SPM) to meet the needs of Montana's MCH population. These are:

SPM #1: The percent of children with cleft lip and/or palate receiving care in multidisciplinary clinics.

SPM #2: The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.

SPM #4: The rate of death to children 0 through 17 years of age caused by unintentional

injuries (per 100,000).

SPM #5: The percent of women who smoke during pregnancy.

SPM #6: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis.

SPM #7: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Varicella.

This performance measure (SPM 02: percent of women who abstain from alcohol use in pregnancy) will not be addressed as one of the state's seven performance measures and will be inactive at the beginning of FFY 2011.

State Performance Measure 4: *Percent of state fetal/infant/child deaths reviewed for preventability by local review teams.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	96	92	88
Annual Indicator	90.2	88.7	90.2	87.2	87.2
Numerator	185	165	156	156	156
Denominator	205	186	173	179	179
Data Source				Mortality reviews and vital statistics	Mortality reviews and vital statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88	88	88	88	

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal.

Notes - 2008
As of 2008, the data reported for this measure are one year behind, to allow for more complete reporting and tracking of trends. Fetal, infant, and child mortality review teams may review deaths as long as 6-12 months after the event, and in some cases completion and submission of reviews may be delayed even longer by a delayed death certificate or other circumstances related to the death. 156 FICMR reviews for 2007 had been submitted as of July of 2009. The denominator is the number of fetal, infant, and child deaths that occurred in Montana or to Montana residents in 2007 and were reported to the Montana Office of Vital Statistics. This definition of the denominator was standardized for the 2009 block grant submission; previous years do not necessarily use the same denominator. The objective was adjusted to be more appropriate for the change in data reporting.

Notes - 2007
The numerator is 2007 reviews completed as of July 2009. Although a few more reviews may be submitted for 2007, the year is nearly complete. Fetal, Infant, and Child Mortality Review teams may review deaths as long as 6-12 months after the event, and in some cases completion and submission of reviews may be delayed even longer by other circumstances relating to the death.

The denominator reflects fetal, infant and child deaths (through age 17 years) that occured in MT to MT residents, as reported to the MT Office of Vital Statistics.

a. Last Year's Accomplishments
Local Fetal Infant Child Mortality Review (FICMR) Teams reviewed child deaths and implemented community activities related to preventability.

The Family and Community Health Bureau (FCHB) sustained FICMR activities with several training opportunities. The FICMR coordinator training, held February 2009, included FICMR review basics, determining preventability of deaths, death certificate information and a mock case review for 13 attendees. During this face-to-face meeting, there was discussion on the current review tool, how to keep local team members involved and an open discussion on prevention activities and lessons learned. The attendees were instructed on how to submit a FICMR review.

The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, "A Summary of Mortality Reviews Conducted in 2005-2006." The report, which highlighted evidenced-based best practices and prevention activities in Montana including firearm deaths, suicide, and motor vehicle deaths was distributed to the local FICMR coordinators and is available online on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-index.shtml

The FICMR and Emergency Medical Services for Children (EMSC) state coordinators attended a National Symposium of State Leaders in Maternal Child Health, Injury Prevention and Child Death Review, "Keeping Kids Alive," on May 20-22, 2009 in Washington DC. Montana specific information, i.e. graduated drivers license, car seat safety education, check stations, and information related to the review of youth fatalities from motor vehicle accidents was highlighted in the presentation for Montana.

The FICMR Coordinator attended the quarterly EMSC Advisory Meetings and provided FICMR information. EMSC prevention information related to prevention was shared with local FICMR coordinators.

FCHB staff attended training, April 29, 2009, on Native American Sudden Infant Death Syndrome (SIDS) prevention sponsored by Healthy Native Babies. The information was shared at meetings with local FICMR coordinators in June 2009.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local Fetal Infant Child Mortality Review (FICMR) Teams reviewed child deaths and implemented community activities related to preventability			X	
2. The Family and Community Health Bureau (FCHB) sustained FICMR activities with several training opportunities			X	X
3. The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, “A Summary of Mortality Reviews Conducted in 2005-2006.”			X	X
4. The FICMR and Emergency Medical Services for Children (EMSC) state coordinators attended a National Symposium of State Leaders in Maternal Child Health, Injury Prevention and Child Death Review, “Keeping Kids Alive.”				X
5. The FICMR Coordinator attended the quarterly EMSC Advisory Meetings and provided FICMR information				X

6. FCHB staff attended training, April 29, 2009, on Native American Sudden Infant Death Syndrome (SIDS) prevention sponsored by Healthy Native Babies				X
7.				
8.				
9.				
10.				

b. Current Activities

The FICMR Coordinator is available as a resource via phone, email, traditional mail or in person and shares pertinent prevention information, current journal articles and information received from national sources related to infant and child death prevention with the local coordinators. The FICMR Coordinator participates on a number of committees, i.e. Injury Prevention Coalition and the EMSC, each charged with addressing preventable unintended injuries.

The FICMR Coordinator utilizes conference calls for local FICMR coordinator meetings. FICMR meetings allow the local coordinators an opportunity to network, share prevention activities and collaborate on lessons learned with their peers, thereby improving the sense of teamwork and effectiveness of FICMR efforts.

The FCHB Epidemiologist works with FCHB staff on a process to review FICMR data on an annual basis, facilitating earlier identification of preventable deaths and earlier implementation of prevention activities. The FCHB assists the local FICMR teams in understanding their data findings and incorporating them into community level prevention activities.

The FCHB promotes prevention strategies statewide by distributing the 2005-2006 FICMR Report, "A Summary of Mortality Reviews Conducted in 2005-2006" which includes community prevention activities. Report is on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-index.shtml

c. Plan for the Coming Year

The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address infant/child deaths. The new state performance measure will be MT State Performance Measure (SPM) 04: the rate of death to children 0 through 17 years of age caused by unintentional injuries (per 100,000).

State Performance Measure 04 addresses Montana's MCH Priority Area of Access to Care which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "to maintain programs that provide services to women (pre-pregnancy, prenatal, and post-natal) and children."

State Performance Measure 5: *Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	23	20.4	19.5	26	27
Annual Indicator	23.3	24.5	26.0	25.6	26.9
Numerator	15374	15066	16793	16378	18178

Denominator	66078	61369	64620	64071	67648
Data Source				Medicaid EPSDT Form16	Medicaid EPSDT Form 16
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	29	30	31	

Notes - 2009
The source for this data is EPSDT, for federal fiscal year 2009.

Notes - 2008
The source for this data is EPSDT. It is run on the FFY 2008.
An updated Medicaid data were published on March 3rd, 2009 for previous years. The released data did not reflect any changes in the numerator or denominator for FFY 2006 and FFY 2007.

Notes - 2007
The source for this data is EPSDT. It is run on the FFY 2007.

a. Last Year's Accomplishments
The Family and Community Health Bureau (FCHB) hired a health education specialist whose duties included promoting oral health education activities.

Access to Baby Child Dentistry (ABCD) training was offered to 77 dental health professionals in May 2009. ABCD was a collaborative effort involving FCHB, the Montana Dental Association (MDA), and the Primary Care Association (PCA).

Quarterly meetings were held with the Montana (MT) Primary Care Association (PCA) to discuss oral health related needs. Five Community Health Centers (CHC) began offering the ABCD Program on April 1, 2009, with the first monthly training provided in June 2009.

The FCHB did not receive the grant for Improving Children's Oral Health in MT.

Open Wide training received continuing education approval from the MT Early Childhood Project. This online oral health education program was offered to child care providers and participants were eligible to receive free toothbrushes for children in their care upon completion of the program.

The FCHB Oral Health (OH) Food Stamp (FS) Project supported the cost associated with producing 5000 posters with the Department of Public Health and Human Services (DPHHS) approved oral health message.

One county selected SPM 05 as its focus and conducted activities to help increase the percent of Medicaid eligible children who receive dental services as part of their comprehensive services.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Family and Community Health Bureau (FCHB) hired a health education specialist whose duties included promoting oral		X	X	

health education activities				
2. Access to Baby Child Dentistry (ABCD) training was offered to 77 dental health professionals			X	X
3. Quarterly meetings were held with the Montana (MT) Primary Care Association (PCA) to discuss oral health related needs				X
4. Open Wide training received continuing education approval from the MT Early Childhood Project			X	X
5. The FCHB Oral Health (OH) Food Stamp (FS) Project supported the cost associated with producing 5000 posters with the Department of Public Health and Human Services (DPHHS) approved oral health message			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Funding was available for the MT ABCD Partnership Program through December 31, 2009. The FCHB Epidemiology Unit analyzed the data and a final report will be written by the FCHB.

The Health Education Specialist participates on the Interdisciplinary Training Committee that was initiated by the Montana Area Health Education Center (MT AHEC). The general purpose of this committee is similar to the MT Oral Health Alliance (MOHA) which was disbanded per the Governor's directive.

The FCHB Oral Health (OH) program produced oral health educational materials which provide age-appropriate materials for teachers of children in grades 1--5. Each section focuses on one grade level and provides a summary of objectives and resources as well as talking points, handouts, coloring pages, games, illustrations, and lessons. Topics include the importance of teeth and oral hygiene, understanding tooth development, tooth decay and prevention, and nutrition.

The Health Education Specialist continues to provide technical assistance and referral services.

The FCHB OH program submitted a grant proposal to HRSA for developing a 5-year strategic plan and increasing the dental workforce in Montana.

c. Plan for the Coming Year
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address oral health. The new state performance measure will be MT State Performance Measure (SPM) 02: the percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.

State Performance Measure 02 addresses Montana's MCH Priority Area of Oral Health (children) which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "to maintain programs that provide services to women (pre-pregnancy, prenatal, and post-natal) and children."

State Performance Measure 6: *Percent of pregnant women who abstain from cigarette smoking.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83	81.6	81.6	82	82
Annual Indicator	81.0	80.6	81.8	81.2	81.2
Numerator	9284	9980	10048	10110	10110
Denominator	11468	12388	12287	12446	12446
Data Source				MT Office of Vital Statistics	MT Office of Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	82	82.5	82.5	83	

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal.

Notes - 2008
The data source for this measure is live birth and fetal death records for events that occurred in Montana to Montana residents, as reported to the Montana Office of Vital Statistics. The numerator includes women who reported no cigarette smoking during pregnancy. The denominator includes all MT residents with a reported live birth or fetal death in Montana in 2008. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance. Vital records data on smoking during pregnancy are based on self-report.

Notes - 2007
Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2007 and reported not smoking during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2007 and reported not smoking during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2007. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance. Vital records data on smoking in pregnancy is based on self-report.

a. Last Year's Accomplishments
The Family & Community Health Bureau (FCHB) staff collaborated with Montana Tobacco Use Prevention Program (MTUPP) to plan a webinar training for Public Health Home Visiting (PHHV) providers and other public health providers on smoking cessation.

Sixteen PHHV sites and six Enhanced PHHV sites were funded. The Family and Community Health Bureau (FCHB) staff provided standardized training on the PHHV assessment tools to the local PHHV providers.

The Enhanced Projects continued to include a support specialist who provided Intensive Case Management to those women at highest risk of substance use during pregnancy.

The PHHV reassessment project developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breast feeding for first 6 months of age; prevention of child abuse and neglect;

immunizations; and early identification and intervention for infants at risk for developmental delays.

The PHHV reassessment process helped redefine data elements and how data related to smoking cessation was collected. Beginning July 1, 2009, a different method of reporting tobacco use was implemented to provide more accurate data on this measure.

FCHB collaborated with PHHV projects to implement the electronic transfer of data elements from the local level to the state level. Staff implemented revisions to the standard software and coordinated software training for local PHHV site staff to capture smoking behavioral data.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. See: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The FCHB staff collaborated with MTUPP and produced a webinar training for PHHV providers and other public health providers on smoking cessation				X
2. Sixteen Public Health Home Visiting (PHHV) sites (which included 5 Enhanced PHHV projects) and one Enhanced PHHV site (on a reservation) were funded	X		X	
3. The Enhanced Projects continued to include a support specialist who provided Intensive Case Management to those women at highest risk of substance use during pregnancy	X			
4. The PHHV reassessment project developed a logic model for project evaluation and a standard set of data elements				X
5. The PHHV reassessment process helped redefine data elements and how data related to smoking cessation was collected				X
6. FCHB collaborated with PHHV projects to implement the electronic transfer of data elements from the local level to the state level				X
7. By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes				X
8.				
9.				
10.				

b. Current Activities

The FCHB continues to fund 16 PHHV programs, which promote the Montana Tobacco Quit Line through information and referrals for pregnant women and infant/family units. The FCHB collaborates with MTUPP to provide online regional training for local health department staff on tobacco cessation strategies for pregnant women.

All the PHHV and Enhanced PHHV sites are being monitored at least once a year by the FCHB staff through on-site visits. The sites are being monitored for their compliance with program requirements and the FCHB staff provides technical assistance as needed. A site visit audit form has been developed and is being used on site visits. A written report of the site visit findings is being sent to each PHHV site.

The PHHV home visitor assesses and monitors the High Risk Pregnant Woman's (HRPW) smoking and other tobacco use status at each face-to-face contact. PHHV clients receive information on the effects of tobacco during pregnancy from the PHHV home visitor.

PHHV sites began entering PHHV client data elements into the common electronic data system as of July 1, 2009. Data on outcomes related to pregnant women using tobacco products, cessation of tobacco use, and referrals to cessation resources is being collected by all of the PHHV sites.

In January and February 2010, FCHB and MTUPP staff collaborated to offer three smoking cessation webinars to PHHV and other public health staff across Montana.

c. Plan for the Coming Year

The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address smoking during pregnancy. The new state performance measure will be MT State Performance Measure (SPM) 05: the percent of women who smoke during pregnancy.

State Performance Measure 05 addresses Montana's MCH Priority Area of Access to Care which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "to maintain programs that provide services to women (pre-pregnancy, prenatal, and post-natal) and children."

State Performance Measure 7: *Rate of firearm deaths among youth aged 5-19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	7	8	8	6	4.2
Annual Indicator	8.5	6.4	5.4	4.3	4.3
Numerator	16	12	10	8	8
Denominator	189318	188200	186887	185954	185954
Data Source				MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4.2	4.1	4.1	4	

Notes - 2009

The data are from 2008. 2009 data were not available at the time of grant submittal.

Notes - 2008

As of the 2005 data, this indicator is calculated using 3-year moving averages. The numerator is the average number of deaths due to a firearm for Montana resident youth ages 5 through 19 in 2006-2008. The denominator is the estimated average number of youth aged 5 through 19 years in Montana in 2006-2008, based on mid-year census estimates.

Notes - 2007
As of the 2005 data, this indicator is calculated using 3-year moving averages. The numerator is the average number of deaths due to a firearm for Montana resident youth ages 5 through 19 in 2005-2007. The denominator is the estimated average number of youth aged 5 through 19 years in Montana in 2005-2007, based on mid-year census estimates. These data were updated for the July 2009 submission.

a. Last Year's Accomplishments
Local Fetal Infant Child Mortality Review (FICMR) Teams reviewed child deaths and implemented community activities related to prevention of firearm deaths.

The Family and Community Health Bureau (FCHB) sustained FICMR activities with several training opportunities. The FICMR coordinator training, held February 2009, included FICMR review basics, determining preventability of deaths, death certificate information and a mock case review for 13 attendees. During this face-to-face meeting, there was discussion on the current review tool, how to keep local team members involved and an open discussion on prevention activities and lessons learned. The attendees were instructed on how to submit a FICMR review.

The FICMR Coordinator attended the quarterly Emergency Medical Services for Children (EMSC) Advisory Meetings and provided FICMR information. EMSC prevention information related to prevention was shared with local FICMR coordinators.

The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, "A Summary of Mortality Reviews Conducted in 2005-2006." The report, which highlighted evidenced-based best practices and prevention activities in Montana including accidental and intentional firearm deaths, was distributed to the local FICMR coordinators and is available online on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-index.shtml

The FICMR and EMSC state coordinators attended a National Symposium of State Leaders in Maternal Child Health, Injury Prevention and Child Death Review, "Keeping Kids Alive," on May 20-22, 2009 in Washington DC. Montana specific information, i.e. graduated drivers license, car seat safety education, check stations, firearm deaths and information related to the review of youth fatalities from motor vehicle accidents was highlighted in the presentation for Montana.

The DPHHS's request from the 2009 Legislature for general funds supporting a State Injury Prevention position was approved. This position is housed in the Chronic Disease Bureau.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local Fetal Infant Child Mortality Review (FICMR) Teams reviewed child deaths and implemented community activities related to prevention of firearm deaths			X	
2. The Family and Community Health Bureau (FCHB) sustained FICMR activities with several training opportunities			X	X
3. The FICMR Coordinator attended the quarterly Emergency Medical Services for Children (EMSC) Advisory Meetings and provided FICMR information				X
4. The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, “A Summary of Mortality Reviews Conducted in 2005-2006.”			X	X
5. The FICMR and EMSC state coordinators attended a National				X

Symposium of State Leaders in Maternal Child Health, Injury Prevention and Child Death Review, “Keeping Kids Alive”				
6. The DPHHS's request from the 2009 Legislature for general funds supporting a State Injury Prevention position was approved				X
7.				
8.				
9.				
10.				

b. Current Activities

The FICMR Coordinator is available as a resource via phone, email, traditional mail or in person. The FICMR Coordinator shares pertinent prevention information, current journal articles and information received from national sources related to infant and child death prevention with the local coordinators via email. The FICMR Coordinator participates on a number of committees, i.e. Injury Prevention Coalition and the EMSC, each charged with addressing preventable unintended injuries.

The FCHB partners with EMSC of the Chronic Disease Prevention and Health Promotion Bureau (CDPHPB). The EMSC coordinator works cooperatively with outside agencies and healthcare teams to implement and evaluate injury prevention programs. The FCHB works with the EMSC Coordinator to incorporate activities for prevention of infant/child injuries, identified by local FICMR teams, into the State Injury Prevention Strategic Plan. The FCHB also works with the State Suicide Prevention Coordinator.

FICMR staff assists local FICMR teams in incorporating data into community level prevention activities.
FCHB staff provides training updates to local FICMR coordinators on how to accurately complete the FICMR data reporting form to ensure consistency in all reviews. The training updates include case examples of incorrect form completion and mock reviews, as well as a review of the 2005-2006 FICMR Data Report which includes community prevention activities.

c. Plan for the Coming Year

The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of seven new state performance measures (SPM) to meet the needs of Montana's MCH population. These are:

SPM #1: The percent of children with cleft lip and/or palate receiving care in multidisciplinary clinics.

SPM #2: The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.

SPM #4: The rate of death to children 0 through 17 years of age caused by unintentional injuries (per 100,000).

SPM #5: The percent of women who smoke during pregnancy.

SPM #6: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis.

SPM #7: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Varicella.

This performance measure (SPM 07: rate of firearm deaths among youth aged 5-19) will not be addressed as one of the state's seven performance measures and will be inactive at the beginning of FFY 2011.

State Performance Measure 8: *Percent of low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		6	6	6	7
Annual Indicator	6.7	7.3	7.2	7.4	7.4
Numerator	772	911	895	931	931
Denominator	11573	12499	12437	12595	12595
Data Source				MT Office of Vital Statistics	MT Office of Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7	6.9	6.9	6.8	

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal.

Notes - 2008
The numerator includes low birth weight (<2500 grams) births to Montana residents that occurred in Montana, as reported to the Montana Office of Vital Statistics. The denominator includes the number of live births to Montana residents that occurred in Montana.

Notes - 2007
The numerator includes low birth weight (<2500 grams) births to Montana residents, as reported to the Montana Office of Vital Statistics. The denominator includes the number of live births to Montana residents. The 2007 data were updated for the July 2009 submission.

a. Last Year's Accomplishments
Sixteen Public Health Home Visiting (PHHV) sites and six Enhanced PHHV sites were funded. The Family and Community Health Bureau (FCHB) staff provided standardized training on the PHHV assessment tools to the local PHHV providers.

The Enhanced Projects continued to include a support specialist who provides Intensive Case Management (ICM) to those women at highest risk of substance use during pregnancy.

The FCHB coordinated the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breast feeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

The PHHV reassessment process helped redefine data elements and how data related to smoking cessation will be collected. Beginning July 1, 2009, a different method of reporting tobacco use was implemented to provide more accurate data on this measure.

FCHB worked with PHHV projects to implement the electronic transfer of data elements from the local level to the state level. Staff implemented revisions to the standard software and coordinated software training for program staff.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. See: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

FCHB and Montana Tobacco Use Prevention Program (MTUPP) staff collaborated to provide tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana.

Work continued on revision of the Service Provision Assessment (SPA) and rules for Targeted Case Management (TCM) as part of the DPHHS TCM workgroup. A rate setting methodology was explored, including a time study of local TCM providers.

Two counties selected SPM 08 as their focus and conducted activities to help decrease the percent of low birth weight infants among all live births.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Sixteen Public Health Home Visiting (PHHV) sites and six Enhanced PHHV sites were funded	X		X	
2. The Enhanced Projects continued to include a support specialist who provides Intensive Case Management (ICM) to those women at highest risk of substance use during pregnancy	X			
3. The FCHB coordinated the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements				X
4. The PHHV reassessment process helped redefine data elements and how data related to smoking cessation will be collected				X
5. FCHB worked with PHHV projects to implement the electronic transfer of data elements from the local level to the state level				X
6. The FCHB developed a PHHV Report summarizing key program outcomes				X
7. FCHB and Montana Tobacco Use Prevention Program (MTUPP) staff collaborated to provide tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana				X
8. Work continued on revision of the Service Provision Assessment (SPA) and rules for Targeted Case Management (TCM) as part of the DPHHS TCM workgroup.				X
9.				
10.				

b. Current Activities
The FCHB continues to fund the 16 PHHV/Enhanced PHHV programs which provide home visiting services for high risk pregnant women to promote the importance of early and adequate prenatal care to achieve healthy pregnancy outcomes.

The PHHV home visitors assess and monitor the status of prenatal care during home visits and

other face-to-face contacts with PHHV clients. PHHV home visitors provide the PHHV client with education on the importance of starting prenatal care during the first trimester and continuing prenatal care until birth of the baby.

All PHHV pregnant clients without health insurance coverage are assisted with the presumptive eligibility process, thus allowing her to access early prenatal care and/or referral to Medicaid by PHHV home visitor.

PHHV sites began entering PHHV client data elements into the common electronic data system as of July 1, 2009. Data on outcomes related to adequacy of prenatal care using the Kotelchuck Index and referrals to health care resources is being collected.

The FCHB staff collaborates with the following: March of Dimes Montana Chapter (to focus on prematurity prevention), the Family Planning Programs in Montana (to counsel and refer clients with positive pregnancy tests to early prenatal care), and WIC providers (to refer pregnant clients to PHHV services and early prenatal care if needed).

c. Plan for the Coming Year

The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of seven new state performance measures (SPM) to meet the needs of Montana's MCH population. These are:

SPM #1: The percent of children with cleft lip and/or palate receiving care in multidisciplinary clinics.

SPM #2: The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.

SPM #4: The rate of death to children 0 through 17 years of age caused by unintentional injuries (per 100,000).

SPM #5: The percent of women who smoke during pregnancy.

SPM #6: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis.

SPM #7: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Varicella.

This performance measure (SPM 08: percent of low birth weight infants among all live births) will not be addressed as one of the state's seven performance measures and will be inactive at the beginning of FFY 2011.

State Performance Measure 9: *Percent of Montana public middle and secondary schools that include comprehensive sexuality education as part of their health curriculum.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective			63	63	70

Annual Indicator		62.6	62.6	62.6	62.6
Numerator		107	107	107	107
Denominator		171	171	171	171
Data Source				Women's and Men's Health Program	Women's and Men's Health Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	70	70	

Notes - 2009
The source of these data are the 2002-2003 Sex Education Telephone Questionnaire conducted by Planned Parenthood. The survey has not been repeated and no future suveys are planned at this time.

Notes - 2008
The source of these data are the 2002-2003 Sex Education Telephone Questionnaire conducted by Planned Parenthood. The survey has not been repeated and no future suveys are planned at this time.

Notes - 2007
The source of these data are the 2002-2003 Sex Education Telephone Questionnaire conducted by Planned Parenthood. The survey included only high schools, therefore middle schools are not included in this first year of data reporting, although the intent is to include them in future surveys. 20 (11.7%) of the 171 high schools did not repsond to the survey.

The data used for this indicator suggest that 25% of the schools reporting comprehensive sexuality education as a part of their curriculum actually only teach about contraceptive failure rates. The definition of comprehensive sexuality education used for this performance measure will be reviewed. As a result, schools that only teach about contraceptive failure rates may not be included in the numerator in the future, which would result in a lower indicator. ahb df

a. Last Year's Accomplishments
The Women's and Men's Health Section (WMHS), of the Family and Community Health Bureau (FCHB), Health Education Specialist (HES) partnered with many different agencies for the purpose of coordinating the work on implementing comprehensive sexuality education into the Montana public middle and secondary school curriculums. Some of the partnerships included the Office of Public Instruction (OPI); the 14 Delegate Agencies (DA) that provide family planning and education services to all 56 counties; the Missoula Adolescent Pregnancy, Parenting, and Prevention Services (MAPPS); the Montana Partnership for Sex Education; the newly formed statewide Teen Pregnancy Prevention Coalition, and several partnerships within Department of Public Health and Human Services (DPHHS), including the HIV/STD Section Supervisor.

The 14 DAS ensured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, educational information, and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on family size and income, also ensured the affordability of family planning services and supplies. http://www.familyplanning.hhs.mt.gov

The HES facilitated the October 2008 "Let's Talk/ Family Involvement Months" and the May 2009 National Teen Pregnancy Prevention Month's activities which incorporated prevention messages that encouraged comprehensive sexuality education by providing toolkits. WMHS surveyed DAs to see if toolkits were helpful and will continue.

During the 2009 legislative session the Healthy Youth Sex Education bill, sought matching

funding to improve teacher training and curriculum resources to improve teen pregnancy prevention and Sexually Transmissible Infections (STI) education in Montana schools. Although the bill did not pass, additional efforts to implement age-appropriate and medically accurate comprehensive sex education curriculum into Montana public schools is being pursued.

Planned Parenthood is in the beginning stages of developing a statewide coalition for teen pregnancy prevention in Montana. One of the efforts of the coalition, in partnership with OPI and the National Campaign to Prevent Teen and Unplanned Pregnancy, will be to train teachers on effective comprehensive sex education curriculums.

The WMHS HES presented information about teen pregnancy rates, best practices, and comprehensive sexuality education at the American Indian Women's Journey conference, the Bozeman Teen Pregnancy Prevention Coalition meeting, the Montana Nurses Association meeting, the Montana Parent Teacher Association (PTA) convention, and the Montana Public Health Association.

WMHS also provided additional training opportunities for public health and family planning staffs that included: a contraceptive update, male reproductive health issues, and adolescent brain development at the Annual Family Planning Conference.

The WMHS Program and the FCHB epidemiologist were key resources for the collection of family planning data included in the 2008 Annual Report. The report was distributed across the state in January 2009 to family planning and other health related agencies.http://www.dphhs.mt.gov/PHSD/Women-health/documents/AnnualReport2009.pdf

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WMHS Continues to provide reproductive health services, technical assistance, and educational and outreach materials.	X		X	X
2. WMHS distributes an on-line newsletter for all the DA's, to provide updated information on teen pregnancy rates and other related information			X	X
3. Meet and discuss materials and family planning priorities with the SPIEC				X
4. WMHS distributes a Teen Pregnancy Prevention Report in coordination with MCH Epidemiologist			X	
5. WMHS seeks out additional funding opportunities for DA's to provide reproductive health services	X		X	X
6. WMHS provides training to DA's through annual training opportunities			X	X
7.				
8.				
9.				
10.				

b. Current Activities

HES coordinated the October 2009 "Let's Talk/ Family Involvement Month" toolkit; the May 2010 National Teen Pregnancy Prevention Month toolkit, which encouraged Das to incorporate the prevention message that encourages comprehensive sexuality education.

WMHS surveyed Delegate Agencies to determine if the educational toolkits are meeting their needs and gather information as to improve future toolkits. The toolkits were greatly appreciated

and helpful for outreach efforts in the local communities.

The Sex Education Coalition began three pilot projects in Missoula, Helena, and Great Falls to assess community capacity and the ability to work the local school boards to implement comprehensive sex education in schools.

The statewide Teen Pregnancy Prevention Coalition, facilitated by Planned Parenthood of Montana, began activities to reduce teen and unplanned pregnancy among American Indians and older teens, the populations with the highest teen pregnancy rates in Montana. Educators and coalition members implemented activities on two Indian Reservations and at the community college in Great Falls.

Planned Parenthood hosted a Wise Guys training in Billings. Health educators and community members from across the state were taught how to implement this evidence-based curriculum.

Contacted Foster care to collaborate on Teen Pregnancy Prevention grant for SFY 2011. Will continue to work with social service agencies providing services for at-risk youth.

c. Plan for the Coming Year

The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of seven new state performance measures (SPM) to meet the needs of Montana's MCH population. These are:

SPM #1: The percent of children with cleft lip and/or palate receiving care in multidisciplinary clinics.

SPM #2: The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.

SPM #4: The rate of death to children 0 through 17 years of age caused by unintentional injuries (per 100,000).

SPM #5: The percent of women who smoke during pregnancy.

SPM #6: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis.

SPM #7: The percent of children 19 -- 35 months of age who have received all age-appropriate immunizations against Varicella.

This performance measure (SPM 09: Percent of Montana public middle and secondary schools that include comprehensive sexuality education as part of their health curriculum) will not be addressed as one of the state's seven performance measures and will be inactive at the beginning of FFY 2011.

E. Health Status Indicators

Introduction

The Health Status Indicators (HSIs) provide a description and overview of the resident Montana population. They are an opportunity for the state to review and consider the current rates and trends for crucial maternal and child health (MCH) issues, such as low birth weight, very low birth

weight, and deaths due to various causes. They also allow the MCH program to assess how the data have been collected and reported in the past and consider how changes in data systems and limitations in data sources may affect the quality of what is reported.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.7	7.3	7.2	7.4	7.4
Numerator	772	911	895	931	931
Denominator	11573	12499	12437	12595	12595
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2007
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence. The data were updated for the July 2009 submission.

Narrative:
Montana's low birth weight rate appears to have been gradually increasing. The low birth weight rate in 2000-2002 was 6.6 and the rate for 2006-2008 is 7.3.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.4	5.6	5.6	5.8	5.8
Numerator	609	676	671	706	706
Denominator	11278	12092	12034	12203	12203
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2007
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence. The data were updated for the July 2009 submission.

Narrative:
Montana's singleton low birth weight rate appears to have been gradually increasing. The singleton low birth weight rate in 2000-2002 was 5.2 and the rate for 2006-2008 is 5.7.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.0	1.2	1.2	1.1	1.1
Numerator	114	149	144	144	144
Denominator	11573	12499	12437	12595	12595
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2007
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence. The data were updated for the July 2009 submission.

Narrative:
Montana's very low birth weight rate appears to have been gradually increasing, although the change is fairly small. The very low birth weight rate in 2000-2002 was 1.1 and the rate for 2006-2008 is 1.2.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.9	0.9	0.9	0.9	0.9
Numerator	98	106	103	111	111
Denominator	11278	12092	12034	12203	12203
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2007
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence. The data were updated for the July 2009 submission.

Narrative:
Montana's singleton very low birth weight rate appears to have been gradually increasing, although the change is fairly small. The singleton very low birth weight rate in 2000-2002 was 0.8 and the rate for 2006-2008 is 0.9.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	10.2	10.7	9.6	11.8	11.8
Numerator	18	19	17	21	21
Denominator	175610	177741	177688	178508	178508
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2007
2007 data were updated for the July 2009 submission. The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
Montana's death rate due to unintentional injury among children 14 and younger has remained fairly stable. Unintentional injury is a leading cause of death for Montanans of all ages. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Approximately 80% of the 2005-2006 unintentional injury deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, at least 90% of unintentional injury deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use by a caregiver, poor or inadequate supervision, and lack of use of available safety measures such as seatbelts or helmets.
In addition, as of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.7	5.6	5.6	6.2	6.2
Numerator	10	10	10	11	11
Denominator	175610	177741	177688	178508	178508
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the

2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2007
2007 data were updated for the July 2009 submission. The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
Motor vehicle deaths are a leading cause of death for Montanans of all ages. While the death rate due to motor vehicle deaths is similar to other leading causes among young children, motor vehicles start to emerge as the primary cause of death among children 6-12. Among older teens and young adults motor vehicle deaths far outpace the other leading causes. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Almost 80% of the 2005-2006 motor vehicle deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, 95% of motor vehicle deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use, lack of seat belt and child safety seat use, inattentive and reckless driving, and driver's inexperience.

In the majority of the 2005-2006 deaths the child was in a passenger vehicle, although the reviewed deaths also included pedestrians, ATVs, bicycles, and motorcycles. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries, and motor vehicle deaths in particular. A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	35.0	43.1	43.2	43.4	43.4
Numerator	48	59	59	59	59
Denominator	137200	136834	136424	136045	136045
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008

The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 15-24 years, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2007
2007 data were updated for the July 2009 submission. The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 15 through 24 years, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2006 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
Motor vehicle deaths are a leading cause of death for Montanans of all ages. While the death rate due to motor vehicle deaths is similar to other leading causes among young children, motor vehicles start to emerge as the primary cause of death among children 6- 12. Among older teens and young adults motor vehicle deaths far outpace the other leading causes. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Almost 80% of the 2005-2006 motor vehicle deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, 95% of motor vehicle deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use, lack of seat belt and child safety seat use, inattentive and reckless driving, and driver's inexperience. reviewed deaths also included pedestrians, ATVs, bicycles, and motorcycles. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries, and motor vehicle deaths in particular.

A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	160.4	169.7	256.9	211.9	211.9
Numerator	284	301	458	381	381
Denominator	177051	177413	178268	179844	179844
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
2008 data are from the hospital discharge data. The numerator includes non-fatal injuries to Montana residents only. The denominator is the census estimate of children 14 years and younger in 2008 (May 2009 version).

Notes - 2007
2007 data are from the hospital discharge data. The numerator includes non-fatal injuries to Montana residents only. The denominator is the census estimate of children 14 years and younger in 2008 (May 2009 version).

Narrative:
Prior to 2007, the data source for this indicator was the State Trauma Registry (STR), the most complete source of data on nonfatal injuries in the state at the time. However, the data from this source is considered to substantially underestimate of the actual rate of nonfatal injuries. Also, trauma registry data was not a good indicator of trends, as the data quality changed from year to year. For instance, in 2007 one of the large hospitals in the state did not report any data to the registry.

Since 2007, the data source for this indicator is hospital discharge data, a more complete source of data than the State Trauma Registry. The data reported for this indicator includes nonfatal injuries for Montana residents only.

Hospital discharge data reporting is not mandatory in Montana, does not include data from all hospitals, and does not include emergency department data. The hospital discharge data that are available do not in most cases include the ecodes required to assess the types of injuries treated. A bill introduced in the 2009 Montana legislature to make hospital discharge data reporting mandatory did not pass. However, a statewide injury prevention program was established, which will increase the focus on injuries and is expected to assist in improving the quality of hospital discharge data. A variety of injury prevention activities take place at the state and local levels, such as safety awareness education, Safe Kids/Safe Communities programs, and other activities targeted through various programs.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	452.4	433.1	398.3	363.6	290.9
Numerator	801	767	710	654	525
Denominator	177051	177112	178268	179844	180465
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Numberator data from MDT Traffic Safety. Denominator data from census estimates.

Notes - 2008

Numberator data from MDT Traffic Safety. Denominator data from census estimates.

Notes - 2007
Source: MT DOT
RR
Update denominator on July 08, 2009 used data from US Census

Narrative:
There has been a steady decline in the motor vehicle crashes among young children in the past few years. The change coincides with the implementation of graduated driver licensing. There have also been multiple public education campaigns and other activities to increase child safety seat and seat belt usage and reduce drunk driving. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on intentional and unintentional injuries, and motor vehicle incidents in particular. A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2,220.1	2,273.7	2,150.2	1,910.2	1,577.9
Numerator	3046	3114	2912	2593	2266
Denominator	137200	136959	135429	135746	143606
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Numberator data from MDT Traffic Safety. Denominator data from July 1, 2009 census estimates (June 2010 edition).

Notes - 2008
Numberator data from MDT Traffic Safety. Denominator data from census estimates.

Notes - 2007
Source: MT DOT
Updated denominator on July 8, 2009 from US Census.

Narrative:
There has been a steady decline in the motor vehicle crashes among young children in the past few years. The change coincides with the implementation of graduated driver licensing. There have also been multiple public education campaigns and other activities to increase child safety seat and seat belt usage and reduce drunk driving. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on intentional and unintentional injuries, and motor vehicle incidents in particular. A variety of prevention

activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	20.1	22.1	23.5	27.7	24.6
Numerator	660	720	794	926	807
Denominator	32773	32551	33850	33488	32789
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2009. The denominator is from census estimates of Montana resident females 15-19 years of age in 2009 (June 2010 version). Reporting for 2009 may not be complete.

Notes - 2008
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 15-19 years of age in 2008 (June 2010 version). The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in cases.

Notes - 2007
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2007. The denominator is from census estimates of Montana resident females 15-19 years of age in 2007 (June 2010 version). The data were updated for the July 2009 submission.

Narrative:
The gradual increase in the chlamydia rate for 15-19 year olds is believed to be due to improved case reporting and an increase in the sites that reported test results. Reporting for 2009 may not be complete.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.2	7.7	7.8	8.4	8.6
Numerator	1062	1140	1158	1249	1292
Denominator	148088	147904	148467	149294	149491
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 20-44 years of age in 2008 (June 2010 version). Reporting for 2009 may not be complete.

Notes - 2008
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 20-44 years of age in 2008 (June 2010 version). The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in cases.

Notes - 2007
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2007. The denominator is from census estimates of Montana resident females 20-44 years of age in 2007 (June 2010 version). The data were updated for the July 2009 submission.

Narrative:
The gradual increase in the chlamydia rate for 20-44 year olds is believed to be due to improved case reporting and an increase in the sites that reported test results. Reporting for 2009 may not be complete.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	12838	10582	158	1330	130	15	623	0
Children 1 through 4	49600	40673	820	5634	491	46	1936	0
Children 5 through 9	58491	48629	1065	6111	525	63	2098	0
Children 10 through 14	59536	50877	915	5280	498	63	1903	0
Children 15 through 19	68108	58723	856	6113	549	53	1814	0
Children 20 through 24	75498	66469	696	5754	861	46	1672	0
Children 0 through 24	324071	275953	4510	30222	3054	286	10046	0

Notes - 2011

Data Source: US Census, July 1, 2009 population estimates.
http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Data Source: US Census, July 1, 2009 population estimates.
http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Data Source: US Census, July 1, 2009 population estimates.
http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Data Source: US Census, July 1, 2009 population estimates.
http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Data Source: US Census, July 1, 2009 population estimates.
http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Narrative:
The data source for this indicator is census estimates.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	12255	583	0
Children 1 through 4	46782	2818	0
Children 5 through 9	55082	3409	0
Children 10 through 14	56555	2981	0
Children 15 through 19	65273	2835	0
Children 20 through 24	72885	2613	0
Children 0 through 24	308832	15239	0

Notes - 2011
Data Source: US Census, July 1, 2009 population estimates.
http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Data Source: US Census, July 1, 2009 population estimates.
http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Data Source: US Census, July 1, 2009 population estimates. http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Data Source: US Census, July 1, 2009 population estimates. http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Data Source: US Census, July 1, 2009 population estimates. http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Data Source: US Census, July 1, 2009 population estimates. http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009

Narrative:
The data source for this indicator is census estimates.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	9	5	0	3	0	0	1	0
Women 15 through 17	363	241	1	105	0	1	10	5
Women 18 through 19	943	661	6	219	9	4	36	8
Women 20 through 34	9899	8380	34	1113	76	16	173	107
Women 35 or older	1337	1209	7	77	23	2	9	10
Women of all ages	12551	10496	48	1517	108	23	229	130

Notes - 2011
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Narrative:
The data source for this indicator is live birth records from the Montana Office of Vital Statistics.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	8	1	0
Women 15 through 17	346	17	0
Women 18 through 19	894	49	0
Women 20 through 34	9572	327	0
Women 35 or older	1301	36	0
Women of all ages	12121	430	0

Notes - 2011
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Narrative:
The data source for this indicator is live birth records from the Montana Office of Vital Statistics.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	87	72	0	13	0	0	2	0

Children 1 through 4	12	8	0	2	0	0	2	0
Children 5 through 9	11	9	0	2	0	0	0	0
Children 10 through 14	16	14	0	2	0	0	0	0
Children 15 through 19	46	37	1	6	1	0	0	1
Children 20 through 24	82	61	0	15	0	0	3	3
Children 0 through 24	254	201	1	40	1	0	7	4

Notes - 2011
The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

Narrative:
The data source for this indicator is death records from the Montana Office of Vital Statistics.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	84	3	0
Children 1 through 4	11	1	0
Children 5 through 9	11	0	0
Children 10 through 14	16	0	0
Children 15 through 19	45	1	0
Children 20 through 24	80	2	0
Children 0 through 24	247	7	0

Notes - 2011
The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

The data are from 2008. 2009 data were not available at the time of the grant submittal. They are expected by be available later in 2010.

Narrative:
The data source for this indicator is death records from the Montana Office of Vital Statistics.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	248573	209484	3814	24468	2193	240	8374	0	2009
Percent in household headed by single parent	21.1	19.2	0.0	33.1	0.0	0.0	47.2	21.2	2009
Percent in TANF (Grant) families	2.5	1.4	3.3	12.8	0.4	2.8	0.0	0.0	2009
Number enrolled in Medicaid	67517	48437	827	17026	237	3	866	121	2009
Number enrolled in SCHIP	25938	16807	94	1739	99	36	1897	5266	2009
Number living in foster home care	2281	1250	73	890	8	5	0	55	2009
Number enrolled in food stamp program	22933	17578	182	4473	58	31	0	611	2009
Number enrolled in	29171	19543	146	5047	48	53	4279	55	2009

WIC									
Rate (per 100,000) of juvenile crime arrests	5147.8	4252.7	84.9	702.8	21.3	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	5.1	4.4	0.0	12.7	0.0	0.0	0.0	5.0	2009

Notes - 2011
Data Source: US Census, July 1, 2009 population estimates.
http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009.

Total % in household headed by single parent from US Census CPS Table Creator (2009).

The numerator is the number of TANF participants averaged over 12 months during FFY 09. The denominator is US Census, July 1, 2009 population estimates.

Data are from MT Medicaid Query Path for 2009.

Data are from MT HMK (CHIP) for 2009.

Data provided by the Montana SNAP program for 2009.

The source is from the MT State WIC Program. Data are for FFY 2009.

Numerator: MT Incident-Based Reporting System. MT Board of Crime Control June 24, 2010. Denominator data are from July 1, 2009 census estimates.

Other and unknown race category includes Black, Asian, Native Hawaiian/Pacific Islander. Data Source MT OPI. Numerator is a dropout count, denominator is enrollment count reported for 2008-2009 school year.

Data provided by the Child and Family Services Division of MT DPHHS for 2009.

Narrative:
The programs that provide the data reported above have very different ways of collecting and reporting the data and do not all have standard categories of race and ethnicity. Data from the programs are often updated and cleaned throughout subsequent years, and so they may not all be final. Census estimates for Montana are often based on very small sample sizes, particularly for specific races. For these reasons, the data for HSI 09A and B are considered estimates, and the summary below focuses on the total numbers reported for 2007 and 2008 instead of comparing numbers by race and ethnicity. This is a general assessment of participation in the following situations as reported in the block grant, and may not match what the programs themselves report.

From 2008 to 2009:
The overall census estimates of children 0-19 in Montana increased.
The estimates of the percent of children in single parent households decreased.
The percent of children in TANF families increased.
The number of children enrolled in Medicaid increased.

The number of children enrolled in SCHIP increased.
The number of children living in foster home care decreased.
The number of children enrolled in the food stamp program increased.
The number of children enrolled in WIC increased.
The rate of juvenile crime arrests decreased.
The percentage of high school drop-outs decreased.

Although the Current Population Survey (CPS) is the only source of data on the percent of children in a household headed by a single parent, the sample size for Montana is so small that it does not always provide valid estimates. During a discussion with the U.S Census Bureau about the CPS estimates for Montana, they recommended not using it as a data source for this measure. However, as it is the only data source available on single parent households, the data are reported for white and American Indian only, as these are two largest population groups (by race) in the state.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	235947	12626	0	2009
Percent in household headed by single parent	15.9	0.6	0.0	2009
Percent in TANF (Grant) families	2.5	2.6	0.0	2009
Number enrolled in Medicaid	64382	3135	0	2009
Number enrolled in SCHIP	25139	799	0	2009
Number living in foster home care	2032	136	113	2009
Number enrolled in food stamp program	22322	611	0	2009
Number enrolled in WIC	27198	1918	0	2009
Rate (per 100,000) of juvenile crime arrests	4907.5	126.3	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	5.0	8.1	0.0	2009

Notes - 2011
Data Source: US Census, July 1, 2009 population estimates.
http://www.census.gov/popest/datasets.html, State by Age, Sex, Race, and Hispanic Origin, 6 race groups- 5 race alone groups and 1 multiple race group, Reporting Year 2009.

Total % in household headed by single parent from US Census CPS Table Creator (2009).

The numerator is the number of TANF participants averaged over 12 months during FFY 09. The denominator is US Census, July 1, 2009 population estimates.

Data are from MT Medicaid Query Path for 2009.

Data are from MT HMK (CHIP) for 2009.

Data provided by the Montana SNAP program for 2009.

The source is from the MT State WIC Program. Data are for FFY 2009.

Numerator: MT Incident-Based Reporting System. MT Board of Crime Control June 24, 2010. Denominator data are from July 1, 2009 census estimates.

Other and unknown race category includes Black, Asian, Native Hawaiian/Pacific Islander. Data Source MT OPI. Numerator is a dropout count, denominator is enrollment count reported for 2008-2009 school year.

Data source is the Child and Family Services Division of MT DPHHS for 2009.

Narrative:
The programs that provide the data reported above have very different ways of collecting and reporting the data and do not all have standard categories of race and ethnicity. Data from the programs are often updated and cleaned throughout subsequent years, and so they may not all be final. Census estimates for Montana are often based on very small sample sizes, particularly for specific races. For these reasons, the data for HSI 09A and B are considered estimates. For additional discussion of this indicator, see Health Status Indicator 09A

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	86773
Living in urban areas	163892
Living in rural areas	85463
Living in frontier areas	0
Total - all children 0 through 19	249355

Notes - 2011
Metropolitan/ Micropolitan designation are from CEIC. Metro is a subset of Urban, therefore it is also included in the urban population. Urban population= Metro+Micro, Rural is everything else.

Metropolitan/ Micropolitan designation are from CEIC. Metro is a subset of Urban, therefore it is also included in the urban population. Urban population= Metro+Micro, Rural is everything else.

Metropolitan/ Micropolitan designation are from CEIC. Metro is a subset of Urban, therefore it is also included in the urban population. Urban population= Metro+Micro, Rural is everything else.

Estimates of children living in frontier areas are not included in the chart because frontier is not a category used by the census and is measured differently than rural/urban. To avoid duplication, it was not included. However, 49 counties in Montana are considered "Frontier" using the definition provided by the National Center for Frontier Communities. The total population of youth 0-19 in those 49 frontier counties is 141,666 (55% of all 0-19 year olds in the state). Likewise, there are 114,643 youth age 0-19 (45% of the total) living in non-frontier counties in the state.

Narrative:
Estimates of children living in frontier areas are not included in the chart because frontier is not a category used by the census and is measured differently than rural/urban. To avoid duplication, it was not included. However, 49 counties in Montana are considered "Frontier" using the definition provided by the National Center for Frontier Communities. The total population of youth 0-19 in

those 49 frontier counties is 141,666 (55% of all 0-19 year olds in the state). Likewise, there are 114,643 youth age 0-19 (45% of the total) living in non-frontier counties in the state. Metropolitan/ Micropolitan designation used from CEIC. Metro is a subset of Urban, therefore it is also included in the urban population. Urban population= Metro+Micro, Rural is everything else.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	972972.0
Percent Below: 50% of poverty	5.5
100% of poverty	12.9
200% of poverty	34.4

Notes - 2011
Data Source: US Census CPS Table Creator, Reporting Year 2008 (This is the most recent year)

Data Source: US Census CPS Table Creator, Reporting Year 2008 (This is the most recent year)

Data Source: US Census CPS Table Creator, Reporting Year 2008 (This is the most recent year)

Data Source: US Census CPS Table Creator, Reporting Year 2008 (This is the most recent year)

Narrative:
Data Source: The data source for this measure is the U.S. Census Bureau, Current Population Survey Table Creator.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	238572.0
Percent Below: 50% of poverty	8.3
100% of poverty	19.0
200% of poverty	43.7

Notes - 2011
Data Source: US Census CPS Table Creator, Reporting Year 2008 (This is the most recent year)

Data Source: US Census CPS Table Creator, Reporting Year 2008 (This is the most recent year)

Data Source: US Census CPS Table Creator, Reporting Year 2008 (This is the most recent year)

Data Source: US Census CPS Table Creator, Reporting Year 2008 (This is the most recent year)

Narrative:

The data source for this measure is the U.S. Census Bureau, Current Population Survey Table Creator.

F. Other Program Activities

The health of the maternal and child health population, which encompasses women of childbearing age (15-44 years of age), including pregnant women, infants, children, youth, (including those with special health care needs) and their families, is of critical importance to the state and nation. Infants and children deserve excellent health services, and the Family and Community Health Bureau (FCHB) has a major role in ensuring that those services are available and accessible through the Title V MCH Block Grant Program. The FCHB also recognizes that education is intrinsically related to public health, and that a truly healthy population is one that is prepared to assess its own needs and plan accordingly. Education and health services work hand-in-hand to improve the lives of all Montanans.

Montana's 2011 MCH Block Grant application provides a look at how the FCHB, through partnerships with public and private organizations will strive to meet the needs of the MCH population.

The Primary Care Office (PCO) contracted with a private company for conducting a Dental Provider Survey, with the results primarily used for determining health professional shortage areas. Additional PCO work includes Primary Care and Mental Health Provider surveys in FY 2011.

Montana's Native American mortality rate is higher than that of the Caucasian rate and the overall rate. The state will continue addressing the state outcome measure assessing the Native American Infant Mortality Rate.

The Director of the Department of Public Health and Human Services has created the Best Beginning Communication Strategic Planning Committee, of which the Maternal and Child Health Coordination (MCHC) and WIC Section Supervisors are key members. The Committee is charged with promoting best beginning services for parents of infants and children 0 to 5 years of age. The Best Beginning services tie in with the MCH toll-free hotline which is a partnership between the FCHB and Healthy MT Kids (formerly known as CHIP).

The Children's Special Health Services (CSHS) Section continues to address how best to solicit information from the CYSHCN parents. Family representatives on the CSHS committee provide input to the FCHB regarding family concerns and needs.

The Governor's Office provides annual Tribal Relations training on issues that impact the Tribal Nations of Montana and the state-tribal relationship. FCHB supervisors and support staff have attended previous trainings and will continue to attend future trainings.

G. Technical Assistance

The Maternal and Child Health Coordination (MCHC) Section is requesting technical assistance in developing action guides based on best practices for the top five National Performance Measures and for the seven new State Performance Measures. The new State Performance Measures address emerging health issues in Montana and the MCHC section would like to provide MCH contractors with credible action guides to address their performance measure selection and effect positive change in their communities.

The state Fetal, Infant, and Child Mortality Review (FICMR) Coordinator and MCH Epidemiologist request technical assistance on implementing the use of the Child Death Review (CDR) Case Reporting System. Guidance would include assistance with training local FICMR review teams on the use of the CDR.

Montana's Oral Health program requests technical assistance to improve and support the coordination and reporting of dental screenings recommended by Association of State and Territorial Dental Directors. The MCHC would like to provide training and information sessions/workshops for the Oral Health Partners who conduct the dental screenings. The trainings would include information on the recommended procedures for conducting the screenings, reporting the results of the dental screenings and information on dental services available to low-income and at risk children which can be communicated to parents.

Montana's Oral Health program requests technical assistance to support the Access to Baby Child Dentistry (AbCd) program by providing guidance, leadership, technical assistance, and/or educational materials to AbCd providers/coordinators around the state who are faced with the challenge of assisting children aged 0-3 establish a dental home and low-income mothers/pregnant women receive critical dental care.

The MCHC Section requests technical assistance to develop new communication methods in order to relay and obtain relevant feedback and communication to and from MCH partners. The MCHC Section would like to provide web based, quarterly updates regarding MCH services and also provide assistance and guidance in meeting MCH goals. MCHC would also use the new communication methods to receive quarterly report/application materials from MCH contractors.

Montana's immunization rank according to the National Immunization Survey is 50th in the nation. Montana is focused on improving its rate by providing education to the MCH BG and Vaccine For Children contractors. The FCHB, in partnership with MT's Immunization Program, is focused on improving the immunization rate. Dr. Paul A . Offit, an American pediatrician specializing in infectious diseases and an expert on vaccines, immunology, and virology would be a speaker at an immunization conference.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	2462222	2434812	2435138		2435138	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	2352266	2475255	2135677		2358969	
4. Local MCH Funds *(Line4, Form 2)*	3510000	4126402	3590998		3777376	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	1025000	1114333	1114333		1046041	
7. Subtotal	9349488	10150802	9276146		9617524	
8. Other Federal Funds *(Line10, Form 2)*	20268575	20268575	20406359		22531055	
9. Total *(Line11, Form 2)*	29618063	30419377	29682505		32148579	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1541815	1344686	1292312		1595215	
b. Infants < 1 year old	1306267	1315972	1220309		1255402	
c. Children 1 to 22 years old	2635260	3262516	2738309		2717490	
d. Children with	1772162	1977028	1798893		1820878	

Special Healthcare Needs						
e. Others	1730137	1692901	1809727		1798819	
f. Administration	363847	557699	416596		429720	
g. SUBTOTAL	9349488	10150802	9276146		9617524	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		93713	
c. CISS	140000		105000		132000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	115000		130000		130000	
g. WIC	14744600		15035980		17012511	
h. AIDS	2080980		1367835		1260714	
i. CDC	100000		0		0	
j. Education	0		0		0	
k. Other						
Immunization	0		0		741049	
PHBG FP	0		140434		126000	
Title X FP	2189500		2406547		2474866	
UNHBS	0		299000		299000	
WIC Farmers Market	57353		57353		57353	
WIC Peer Counseling	56064		0		203849	
Immunization	0		715645		0	
WIC peer counseling	0		53921		0	
NBHS	150000		0		0	
PHB FP	140434		0		0	
Youth Suicide Prev	400000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	3710888	4370506	3988114		4004151	
II. Enabling Services	2523031	2353774	2011403		2304937	
III. Population-Based Services	2043517	2164900	2034981		1994812	
IV. Infrastructure Building Services	1072052	1261622	1241648		1313624	
V. Federal-State Title V Block Grant Partnership Total	9349488	10150802	9276146		9617524	

A. Expenditures

The Family and Community Health Bureau (FCHB) Financial Specialist and the Public Health and Safety Division's Fiscal Bureau Analyst maintain the budget documentation for Montana's Maternal Child Health Block Grants, including assuring compliance with state and federal regulations and completion of the Financial Status Reports.

Montana's MCH Block Grant 2009 Annual Report and 2011 Application reflect the importance of local partners for providing MCH services to the population. For FY 2011, approximately 41% of the MCHBG will be distributed through contracts with 55 of the state's 56 city-county health departments.

Montana, along with most other states, is not initiating new programs at this point, instead carefully monitoring state funding and working to maintain existing services. The FCHB will continue to seek additional financial resources, as well as develop new and maintain existing relationships with public and private partners for the intent of increasing the services to Montana's maternal child health population.

The following is a summary of Forms 3, 4, and 5.

Form 3:

Montana's total expenditures to support MCH services has increased by about $2 million over the last five years. Local and state funds and program income have increased, especially since 2007, while federal support has decreased. Increases are attributable to ongoing commitment of local funds to MCH services, state funding to support new and expanded MCH programs, such as a newborn screening follow up program and contraceptive support, and active pursuit of billing funding to support clinics for children with special health care needs. See attached table and chart for Form 3.

Form 4:

Montana's expenditures by population group differed only slightly from 2008 to 2009. An increase of about $150,000 in administrative costs is attributable to cost allocation increases at the state agency as well as to slight increases in administrative costs at the local level.

Form 5

Expenditures for direct health care, enabling, population-based, and infrastructure building services vary from year to year, due in great part to the local MCH contractor's yearly expenditure reports.

An attachment is included in this section.

B. Budget

Montana's proposed Maternal and Child Health (MCH) Block Grant budget for FFY 2011, as reflected on Form 2, includes the following budget items:

Primary and Preventive Services for Children: This budget item includes the anticipated amount to be spent for infants, children and their families. At the state level, this line item reflects the Maternal Child Health Coordination Section and county level MCH contractors who are responsible for providing these services. The FFY 2011 amount is $809,683.

Children with Special Health Care Needs: This budget items includes the Children with Special Health Services Section's budget of $730,541 plus $108,125 from the county level MCH contractors. The FFY 2011 amount is $838,666.

Title V Administrative Costs: This budget item includes the state indirect total of $174,087, plus an anticipated amount of $57,322 from the county level MCH contractors. They are allowed to use up to 10% of their award for administrative costs per the MCH Administrative Rule 37.57.1001. The FFY 2011 amount is $231,409.

The unobligated FY 2011 balance is $0. Montana continues to budget and expend to the level of the annual award.

The State MCH matching fund amount for FY 2011 is $2,358,969 which includes state general funds for the Public Health Home Visiting/ Montana's Initiative for the Abatement of Mortality in Infants Program, the newborn screening program, and family planning programs. The local county level MCH contractors are anticipated to overmatch their allocated MCH Block Grant fund amount. The FFY 2011 local county level MCH amount is $3,777,376.

The MCH Program income for FY 2011 is $1,046,041.

Montana's FY 2011 Maintenance of Effort remains at $485,480, resulting in the Federal-State Title V Block Grant Partnership as $9,617,524. Montana also receives additional federal grant funds, i.e. SSDI, CISS, Title X, Immunization, Universal Newborn Hearing Screening, which total $3,902,117.

For FY 2011, Montana's state MCH budget total is: $32,148,579.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.